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Official Report of Debates (Hansard)

Monday 14 January 1991

Standing committee on
social development

Children's Mental Health
Services

Assemblée législative de l'Ontario

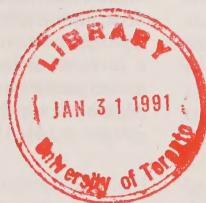
Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 14 janvier 1991

Comité permanent des
affaires sociales

Services d'hygiène mentale
pour enfants



Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
Greffier : Lynn Mellor

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 14 January 1991

The committee met at 1334 in committee room 2.

CHILDREN'S MENTAL HEALTH SERVICES

The Vice-Chair: I call the committee to order. I have no brief announcements to make before we head into our presentations. They are both dealing with the schedule. The first one deals with consideration of two groups that want to appear before the committee. As members are aware, the subcommittee determined which groups would be allowed to make presentations. That was done prior to our meetings here and each caucus submitted lists.

One of the two groups is the EarlsCourt Child and Family Centre. The clerk and members of the committee were contacted by Ken Goldberg of EarlsCourt requesting that its committee be allowed to make a presentation to our committee. The other one is the Ontario Public School Boards' Association and the same request has been made. I would recommend that if the committee agrees, we schedule these two groups on Tuesday, one at 4 o'clock and one at 4:30.

Mr Beer: Agreed.

The Vice-Chair: The other matter is with respect to the time that each presentation will take and the order of questioning. I just want to bring to everyone's attention that under standing order 123, we do have limited time—2 hours in total. That also has to include time for preparation of our report and time for questioning and presentations, so we must adhere to the strict rule of a half-hour for presentation time. I will try to be as fair as possible in allocating questioning. I will try to allow each party one question. I think that is the fairest way to proceed on each presentation.

There is also the matter of Donna Roundhead of Nodin Counselling. She was unable to attend and asked that Charles Morris of Tikinagan Child and Family Services be scheduled in her place. That is tomorrow. I bring that to the members' attention at this time.

If there are no other questions or discussion, I would ask that we turn our attention to our first presentation. Is there a question?

Mr Martin: I am sorry I am late. I flew in from the north and it is pretty stormy out there today. I have a couple of questions I would like to ask. They may already have been asked or addressed.

The Vice-Chair: Would you like to catch your breath first?

Mr Martin: Yes.

The Vice-Chair: We have not started the presentation.

Mr Martin: I know that this is a particularly serious undertaking. The topic of the day is one that concerns me and, I am sure, everybody who is here in a major way. I want to make sure personally that the crack we are getting

at it now is a good one because I know from my own personal experience in the north that there are many children suffering for a million reasons, but a lot of it is because we have not been able to provide the services necessary to give them and the people who work with them the support they need.

I have a couple of concerns that I would like to raise.

The Vice-Chair: Excuse me for a moment. Is this dealing with the question of scheduling groups?

Mr Martin: Yes, it is.

I recognize, looking through the list, a lack of participation by a whole lot of folks in the north who should be here. Not only that, but I brought this up before when we talked about how this might be set up. You do not really get a picture or a sense of the true problem that exists in the north if you do not in fact go up there, have a look yourself and talk to some folks in some more informal settings where they actually operate and live, as to just what is going to be an answer to some of the problems these people are facing.

It concerns me deeply that, first of all, there are not more people from the north making presentations from a wider cross-section of communities and that we have not, in our corporate wisdom, decided somehow to go up there and have a look ourselves. I know that we are limited by some of the legislation around this regarding the 12 hours and all that kind of stuff, but I also know that as a committee, if all of us decide that we want to do something, there is nothing to stop us from doing that, from what I understand. If everybody decides to expand or go beyond the hours that are now available to us or the ways and means of hearing from folks who seem to be inherent in the package that is in front of us today, we should perhaps look at that and seriously consider some other things.

The Vice-Chair: Could I just interrupt? If the committee might look at those matters that you bring before us, we can do that at the end of the day because I do not want to hold up our committee hearings. Many of the people who are presenting today have come from far and wide and I would not want to delay their presentation time.

Mr Martin: I realize that, and I hope you also recognize that I have a real concern that from the very beginning this thing get off on the right foot. I want to make my concerns known.

The Vice-Chair: We have a subcommittee agreement from all three parties that we would proceed in this fashion. The scheduling was worked out by all three parties.

Mr Martin: I will not take too much more of your time, if you do not mind, to present one other point.

The Vice-Chair: Okay. I will allow you another moment just to make your last point.

Mr Martin: My last point is that I do not sense or see in the list of witnesses who have come to present today a very wide representation of those whom we might consider advocates and parents of children, and also some of the children themselves; perhaps not the ones who are in stress today, because they may not be in a position to come and present here and feel comfortable, but certainly there are those who have gone through the system whom we might have in to speak to us and share with us what the concern is in all of that.

The last point I would like to make is, I really appreciate the fact that the Progressive Conservatives brought this forward at this time because I think it is a good time and a good topic to begin our session as a committee.

1340

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

The Vice-Chair: Without further ado, I would call upon our first presenter, the Honourable Zanana Akande, Minister of Community and Social Services, to make her presentation. Welcome to the committee.

Hon Mrs Akande: Thank you very much. I must apologize to all of you for reading my presentation. It was on the best advice that I was given, so you will forgive me if I stray from it. I am not accustomed to speaking from this kind of note.

Thank you for the opportunity to meet and talk with you about the challenges of children's mental health services in Ontario. It is a timely discussion and one which requires our attention and energy towards effecting a solution.

In my many roles, previous and current, as a parent, as a teacher, as a special education consultant, as a volunteer and a committee member to many committees on children's services, including the Advisory Committee on Children's Services of the Ministry of Community and Social Services, I have been involved extensively with children and their families. This involvement has allowed me some knowledge of the needs of children and the family. More important, this involvement has emphasized the importance of a continuum of service for children.

Our mission, our vision, is to develop a comprehensive approach to the children and families of Ontario. To meet that challenge, we have to confront the causative factors of disadvantage: poverty, unemployment and deprivation, and cultural difference. In addition, we must also have a system of services in place that responds quickly and appropriately to individual needs. Only by effecting fundamental changes can we achieve our vision of a child- and family-oriented human services system.

Many forums are now talking about issues that relate to our children, in international circles as well as within communities and neighbourhoods all across this province. Here is our opportunity to meet and talk together, freely presenting our concerns and seeking solutions in the frank and open spirit that characterizes our government.

Change is in the air, and change is happening very rapidly. The world is changing, countries are changing and

local circumstances affecting children and families are changing. We need to be ready to respond appropriately and make sure that our service systems adapt to the realities of the present.

Recently, my ministry received the report of the Advisory Committee on Children's Services. It is called *Children First*, to underline its basic concept that children should have first call on society's concerns and capacities and that children should be able to depend on that commitment in bad times as well as good. The report states that without different kinds of supports for children and families to reflect the new realities, the gap between the supports that are needed and those that are provided will continue to widen, that this will occur in spite of the substantial investment Ontario has made in services for children.

The advisory committee concluded that what is required for substantive change is a comprehensive approach for helping children and families that takes into account the expertise and resources of all the systems involved with children. Additional resources may be needed, but this cannot be determined until current resources are more effectively deployed on behalf of children. The report reiterates my own conviction that we need to make fundamental changes in the way we plan and provide services to children.

The message is coming to us from many directions. A recent report from the Ontario Teachers' Federation points out that communities are expecting schools to meet the individual needs of students, something that cannot be done without a network of community resources: local government, health services, youth-serving organizations, private businesses and the philanthropic sector.

The Premier's Council on Health Strategy and the Premier's Council on Industrial Competitiveness have both identified the importance of investing wisely in social policy for children and for youth. Health and social services, income and material supports, education and training are recognized as being essential for the health of the child and also for the social and economic wellbeing of society. The council submits that children should be seen as able participants. They have certain fundamental entitlements in their own right, not merely as extensions of their parents.

The Sparrow Lake Alliance on Children's Mental Health, which included professionals, ministry representatives from Health, Education and Social Services and community representatives, recommended better integration of services for children at all levels.

The message comes through loudly and clearly. We have to look at the whole picture. We have to talk and listen to each other and work together. We have to make changes and they must be comprehensive changes. Our response to children who are hurting must be enacted across ministries and across service sectors. As the advisory committee report put it: "There is no real system for children. We must create a children's system that has a shared vision of children's entitlements. We must establish mechanisms to put the vision into practice and to make the system workable."

I agree. If we are to be effective and make a difference in the lives of children and families, we need to create a system that is truly flexible, co-ordinated and integrated, a system that will ensure that each child and each family receives appropriate service when they need it. I see four basic principles for that system: empowerment, consultation, co-operation, accountability.

By "empowerment," I mean the need to give individuals more choice and more say in the services they require and how they should be accessed, to allow them to move away from the paternalistic control of the professionals and determine for themselves what is best for them.

"Consultation" means to me listening to and heeding what we are already hearing from committees and forums and it means talking to a lot more people. I want to hear from people who have not spoken up or whose voices have not been heard before. I want us to pay attention to and learn from our past undertakings and build on our successes. For example, there is the Better Beginnings, Better Futures initiative, which is testing the value of primary prevention for children at risk, and the interministerial committee on services for children and youth, which is working to develop co-ordinated and integrated services for children. Both these initiatives embody my third principle, that of co-operation, and reflect the importance of cross-jurisdiction and cross-ministry collaboration.

Lastly, we have to be ever mindful of our accountability. Let's try out new ideas, yes, but let's evaluate them as we go and make sure our programs are providing the service they are meant to provide. We cannot afford, in any sense of the word, to misuse our resources.

I said earlier that we must build on our past successes. We must also learn from our problems and this is where today's committee has much to contribute. The range of expertise and the witnesses who are appearing will serve to broaden our understanding of the issues and, I hope, offer suggestions on ways to address them. I anticipate that the work of this committee will help to inform my ministry and the government as we seek new ways to alleviate the distress of people in need.

The vision we share for the children of Ontario is achievable. My personal commitment to realizing that vision is this: I will seek ways to link the various bodies who have expressed concerns and ideas about children and families so that they may work together to achieve consensus and find solutions. I pledge to you today my wholehearted leadership in this all-important undertaking.

The Vice-Chair: We have 15 minutes for questions.

Mrs McLeod: Madam Minister, I appreciate your opening comments. I think we are all excited about the vision that is set out in the Colin Maloney report and we will have a little time, at least, for the committee to spend some time with that report, I know. But I think it is essential that as we look towards a vision that we do in fact build on what currently exists and that we have a clear understanding of the current situation so that we know the kinds of problems that have to be addressed.

1350

I was very interested that Craig Shields was appointed by the ministry to examine the concerns of the Ontario Association of Children's Mental Health Centres related to the waiting lists and the way in which those waiting lists could be managed. We have not seen the findings of that report yet. I wonder whether or not it is complete and whether you have some sense of his findings and the recommendations it contains.

Hon Mrs Akande: We have been told that we could expect those recommendations would come to us by the end of January or the beginning of February, and we are looking forward to them with much impatience in order to address that.

Mrs McLeod: A supplementary question to that and then I will yield the floor: I am obviously interested, as all of us are, in the results of that particular study, but I have a little bit of a concern even before it is presented that we might tend to define the need and limit our understanding of the need in terms of the waiting lists. I am recalling an old study—I do not have it in front of me—that suggested that maybe 50% of children who in fact need mental health services are even being referred to existing centres. So even if we find that the waiting lists are long, that may only be the surface of the problem that needs to be addressed. I am wondering, given your background of experience in the school system, where you often see the children who perhaps need referral, whether you concur that waiting lists alone are not the indicator of need.

Hon Mrs Akande: I do agree that waiting lists alone are not the indicator of need. I also am concerned about the waiting lists and I am concerned with the basic definition. Let me explain what I mean by that. Certainly if one child is waiting, it is too many children who are waiting. Let us be clear about that. Our focus is to address the needs of children and the waiting lists are not the thing that propels us; it is the fact that we want to present a continuum of service to all children who need it.

My concern with definition is one that also comes out of my experience, because as we define children so shall we address their needs. If we define them as requiring treatment, so shall we treat them, and if we define them as having behaviour difficulties, then we address them differently. I think that is extremely important, because frequently children wait on a waiting list for some specific service or treatment and are found later not to require that intense, that extreme, that in-depth service.

I also think that sometimes we do not often address children's needs by using the multiplicity of people around them. By supporting parents in parenting and supporting teachers towards better procedures for handling children who are somewhat difficult, we may be preventing children from being identified as exceptional who in fact have less than that problem.

That is not to diminish the importance of the lists. It is rather to say: "Yes, there are many children who are not on lists who have needs. Also, there are many children who are on lists whose needs are ill-defined."

Mrs McLeod: I think all we can do with our committee hearings is begin to open some of the questions. As a one-time practitioner in the field, I would love to have an opportunity to discuss it in more depth, but I will pass to another person.

Mrs Witmer: To the honourable minister, I am pleased that you have prepared this report for us. I know from your own background that this is an interest you have. I have a similar background to your own and that is certainly the reason I put this recommendation forward for the consideration of this committee.

I guess one of the things that concerns me the most as both a teacher and a former trustee is the fact that children were falling through the cracks. Although the Ministry of Community and Social Services has some responsibility, the Ministry of Education has some responsibility and the Ministry of Health has some responsibility, no one was willing to assume the responsibility for the co-ordination. Because of the individual mandates and because of the budget restrictions and because of territoriality, I feel this is one of the reasons we have a gap in the delivery of service to these children who are desperately in need, children with social, emotional and behavioural difficulties.

Minister, would you consider or have you considered the establishment of some sort of a co-ordinating body?

Hon Mrs Akande: Actually, I am happy that you have raised that question because it is one I addressed in a very surface way in this report when I talk of a continuum of service. We have already begun meetings at the minister level and also at the assistant deputy minister level to address this question of interministerial co-operation.

We really do feel that children and families should have a continuum of service. It should not be, as you describe it, lockstepped into Education and Health and Community and Social Services and Tourism and Recreation, because they do in fact fall through the cracks. You are quite right.

More than that, when those services are addressed from that kind of vantage point, they are artificial and they are unreal. Who is to say that a child's problem is addressed by a social worker in Education from 9 to 4 and at 5 o'clock it is somebody else's? It is certainly an artificial way to address the problem. So we have begun that.

We have also begun other committee opportunities to address this whole thing of the provision of revisions in the way children's services are provided so that they are not blocked into little segments.

Mrs Witmer: When you are looking at an advisory committee of some sort and you are looking at a central focus for the provision of services to children, have you considered using the schools?

Hon Mrs Akande: We looked at and we are still looking at using many services. I would not say that we have removed that from our consideration, but I would say that it is important for us to use community-based services that are not owned by any one institution that is currently there, but are rather owned by a community process which

defines or allocates services according to need when need is there.

If you put the services in the schools—we are just in the process of considering it—having come out of schools, we know that when you put the services in the schools, they are therefore defined by the structure that is already in place, that some time is not the most progressive or creative.

Mrs Witmer: I was surprised and disappointed that you mentioned the need for maybe additional funds. I would suggest that at the present time children's mental health services are severely underfunded.

Mr Martin: I have been hearing for a bit now the discussion around the approach and you elaborated a little bit further here. Are there any other things that are happening there right now that you think we should perhaps know about as a committee and that we should consider as we put together some recommendations?

Hon Mrs Akande: One of the things we are doing as a preface for this or as part of it is trying to identify services that are required by children as a part of prevention, as well as those that are required for those who have already, to use your expression, fallen through the cracks. We cannot afford to continue to support a system that feeds children into the same process that they are in, because obviously that does not work. The other thing is that we are trying to identify where those supports might be put in the system now for those children who are already having difficulty.

I have a great deal of difficulty with maintaining a child supposedly on a waiting list without service while there are others who can provide service for that child with whom the child is readily in contact. I am not saying that any service from anybody is as good as what this child specifically needs, but I am saying that some of those children must be defined in terms of their needs so that we can meet them more appropriately.

There are plans towards greater definition, plans towards using the facilities that we have better, in a way that can meet more children's needs without just adding more services, but there are also plans to look for where that need might be necessary and to add that.

1400

Mr Martin: I have a supplementary on that—I had another question and I will try to put them both together—and on some of the logistics around that. You have got bureaucracies now out there in the communities that are very into their own territory and protective and that kind of thing. Having worked with social planning councils trying to help determine in communities if needs are being met, if not, how can we readjust mandates of groups, and how difficult all that is?

You also talked about reaching out to groups that have never been heard before, children, parents, in all of that. Have you any thoughts about how that might be done? I see it as a huge problem.

Hon Mrs Akande: Well, certainly it may be done through our area offices, plus I am, on my own particular campaign, travelling around this province trying to learn

more about what is out there and what is not, rather than just what is reported to me on paper. I am planning to consult with and I have already begun to consult with various groups that are involved with children's mental health services. Certain groups have already been meeting with me the last week and previous to that, and I will be going out to meet with others: consumers, past users, children, parents, as well as professionals.

The Vice-Chair: I have Mr Jackson on the list, Ms Haack and Mrs McLeod. We will proceed in that fashion. I am informed we have seven minutes left.

Mr Jackson: Minister, by week's end we will have met with several groups, and some of us are quite familiar with their presentations. The faces and incidents will change, but it is clear that we will be presented with a picture in this province that is not very positive about the demand for services. We also know that the economy is in a degree of difficulty and that people, especially children, are trapped, whether it is in an abusive situation or whatever, and that their mobility to flee from some of these situations is limited as well.

My question has to do with the top of page 4. You make what I think is the most unusual statement in your address, "Additional resources may be needed, but this cannot be determined until current resources are more effectively deployed on behalf of children." Then the report reiterates your "own conviction that we need to make changes in the way we plan and provide services to children." I read that several ways, but the frightening way to read it, of course, is that you currently are not pitching the Treasurer with respect to additional funds.

Prior to the last election it was very clearly your party's position, and our party's position, before the government of the day that there should be a large injection of moneys to deal with the backlog in tandem with these kinds of improvements and changes which—some are complex and some are simple, but we would not want to read into this that we are basically going to be studying this during the course of a year or two. Nobody talks time lines, nobody talks dollars, but clearly the situation is worsening, not getting better, while we study it.

I know by the end of this session, meaning this committee inquiry, that we are going to be left with a compelling sense that this is an issue that simply must not just be studied at this time but also that we must be reacting. That will perhaps surface in our report.

I am looking to you, Minister, for this incredible statement that "additional resources may be needed" when in fact it is abundantly clear to everybody that additional resources are required immediately.

Hon Mrs Akande: You have assumed, Mr Jackson, that I have not begun to knock at the Treasurer's door and I would at least say that this is an assumption that probably only you share. I will say—

Mr Jackson: You did say you were asked to read your report and I see that this was prepared for you, but I know that perhaps there may be—

Hon Mrs Akande: Prepared for me by my input, but I do appreciate your description. Thank you.

Mr Jackson: Thank you.

Hon Mrs Akande: One of the things that we have done, and why I put that statement there, is that I do recognize the great importance of defining the use of services. May I give you, by way of an example, some of the horror stories that exist within our own service education. May I explain to you that very often if children's services are misapplied, it uses services wrongly, so I am not suggesting that we have the problem solved. I am suggesting that there are two things we must do. We must define how children's services are applied so that children are getting the correct thing they need. For example, many of the culturally different children are seen as behaviour problems in some of our schools in situations and that is unacceptable.

Mr Jackson: I am sorry to interrupt, Minister. I am aware of that. I simply asked you about dollars and cents.

The Vice-Chair: I am going to have to interrupt. I would allow one question on your behalf—

Mr Jackson: I have heard this answer before. That is why I interrupted. I apologize for the interruption. I asked a dollars and cents question approaching the Treasurer. That was all I asked the minister for, the sense of urgency she was applying to look for additional resources. That was my question. I am aware of her response on several occasions with respect to how complex the issue is, and I thank you.

The Vice-Chair: I just want to remind members there is a time constraint.

Mr Jackson: That is why I interrupted.

The Vice-Chair: I have two more questioners, so I think we will move on to the last two questioners because we only have four minutes left. I see we are going to have to have a little more patience and perhaps I will intervene when I think it is appropriate, but I will allow the minister—I apologize—to respond and finish her response. Then I will move on to the other two questioners.

Hon Mrs Akande: As I said before, Mr Jackson has really assumed that I have not approached the Treasurer. I have actually looked in many ways and in many different places for additional funds in order to meet this need. I am also involved in making sure where the need exists so that it be more appropriately and effectively met.

The Vice-Chair: One short question if you would indulge the committee and then I will move on to Mrs McLeod.

Ms Haack: There has been, I believe by the previous questioner, an allusion to the fact that possibly more study is required. From your presentation and other things I have read on the topic, I see there is really quite a wide array of studies available. How is your ministry responding to this plethora of information?

Hon Mrs Akande: Actually, when we talk about study we are not studying to see whether in fact there are children who require services. We are looking at ways in which those services may be applied more effectively. We are looking at how those services are being applied in certain instances that create such a great waiting list. We

are looking at where those services are needed. There are uneven facilities in Ontario, so there are areas where there is a greater need than others. We are looking at the distribution of those services in such a way as to meet those needs, but we are also looking at the need, and where that need may exist, for more services.

Mrs McLeod: I want to ask you about the process for review and responding to the Maloney report, although I must preface that by saying I was somewhat concerned by your earlier response to Mrs Witmer's question. I trust that your response, seeming to suggest a real hesitation about services being located in the schools, based on a traditional understanding of what takes place in the schools and how that can be limited by the traditional structure, does not close the door to looking at the Maloney report recommendations which would see the school as the hub for some very non-traditional services. I see you shaking your head and I trust that the door is in fact open. May I ask you, then, what is the process by which you will be reviewing and responding to those recommendations?

Hon Mrs Akande: We have been studying those recommendations and we are putting out a synopsis of the paper plus the paper itself, and asking people to respond to that as a form of consultation. We are also making presentations within communities, at schools, at children's centres, at community centres, to child care centres and parents, to make as wide a presentation as possible in order to get as many responses to that as possible. Yes, you are right; I have not closed the door on schools. I am just concerned that we not consider only schools as a place where these services may take place.

The Vice-Chair: That concludes the end of our first presentation. I wish there was more time because members are obviously very interested and were sparked by your remarks. It will carry us forward into the next two or three days. Thank you, Minister. You are welcome to stay if you would like.

1410

ADVISORY COMMITTEE ON CHILDREN'S SERVICES,
CATHOLIC CHILDREN'S AID SOCIETY OF
METROPOLITAN TORONTO

The Vice-Chair: Our next presenter is the Advisory Committee on Children's Services, Catholic Children's Aid Society of Metropolitan Toronto, Dr Colin Maloney, who is the chair.

Welcome to the committee, Dr Maloney. Please speak into the microphone directly in front of you and introduce yourself. I would also take this occasion to remind you of our strict adherence to a half-hour for your presentation, as we are constrained by our time limits on this committee.

Dr Maloney: I should thank the committee for the opportunity to come here. As you know, the committee has just presented its report. Each of you received this report, of course, and I am sure over the holidays had time to read it. I would like to speak from the basis of that report to the issue in terms of the needs of children and I would like just to make actually three main points.

The first question is, are there greater needs today than before? By "before" I mean within the last 10 years. It is a very difficult question to answer. Many will affirm very clearly that the needs overwhelm our present resources.

Quickly look at the world of children. Whether you look at the factors in the report, whether you look at the factors of what is happening to the world of children, many more of them, in one sense, live in poverty, live in a family that struggles. Many more of them live in a single-mother situation and have to struggle much more than those that have double incomes coming into the family. We look at the divorce rate that now nearly reaches 50%; we look at the issues of family violence, of abuse. You know all these.

Does that world cause more pressure? Does the fact that most mothers who have children have to or want to work put more pressure, would you say, on those families? That is a very hard thing to prove. I think most people feel that there is more pressure and that the children of today face things like drugs. We look at our schools and we ask for AIDS education, drug education, sexual abuse education. When you and I were children, we did not have those.

Let's be clear. My first hypothesis in the report is that it is much more difficult. I do not want to exclude the fact that—whatever it is, 75%—a large number of our kids do very well. But is it acceptable to the Legislature of this province that we have a significant percentage now—20%, 25%, whatever it may be—who do not make it well? Whether it is from an educational point of view or from a psychological point of view, we have a large number who do not make it.

I think you will be very convinced by the presentation that we do not have the resources to respond adequately to that growing need. That is my hypothesis that we start with. If you do not believe that, I will ask the people who speak after me to convince you of it.

This committee brought forward and said that to expand those resources is going to be very difficult financially. As you kept asking the minister, where were the moneys? What was going to be the solution the committee proposed was that obviously it was clearly a direction we would like to strongly put forward to this committee, that we are much better at growing children than fixing them and that to grow children well is what this committee should be all about.

I took the example that very many of you have struggled with in terms of the health of this province. Very clearly you would say, do we need good hospitals? We do need them. Everybody wants them when they are sick, but no one I know of recommends that the solution to our health issue is to have better and more hospitals. There has to be something different. We said we have to have a healthier Ontario, we have to have health promotion.

In this report I wish you would really pick as a strategic direction, can we have a healthier world for children? Can we have a promotional strategy that supports parents both in the workplace and in the pre-natal time, in that time that is so crucial to children in terms of parental leave? Can we have a support structure for parents so that there is a partnership for children, so that we will

have many less children who need to be fixed because the home they have had could not take the pressure?

It depends on this government to see that there is the support, that there is a clearly promotional agenda for children. Otherwise, you face an economy that will not have enough children to work when they become adults. You face an economy that needs people who need more and more resources you do not have. Otherwise, you face a 20% dropout and failure rate that no business can tolerate, let alone a government and a society.

So we ask that our first strategy be a promotional support that enters into partnership both with business, the private world, and the social service world, to much better support those first five years of children's growth.

Second, we have asked that the fragmentation of service, which is notorious—who looks after children from a holistic point of view? Who plans, who sets priorities, who determines what is the best use of these moneys that we as a province spend? Nobody. If we ran, to achieve something, a business that was so fragmented and expected to be successful, we would consider ourselves foolish. Yet in terms of children, we feel it quite all right to have thousands of agencies without any co-ordination on an overall basis either from the government or in the field.

I would like not to take much more time, but to leave some time for your own questioning. I do not think anyone in this province will argue with any government that spends money on children. What they will argue with is that you do not waste it.

My sense is that you say the second major strategy that the committee looked at is that children are too precious a resource for us to allow fragmented and disorganized services. The tool on which we base our planning for the cost-effective use of our response to children is no longer acceptable when we have the means and ability to co-ordinate it and to set priorities in a way that truly would be in the best interests of children.

Those are the two major directions I thought I should bring forward to the committee. I would like to quite willingly receive any questions on the report that you may have or on the specific directions we gave on how that co-ordination should be done.

Mrs McLeod: I regret that we only have half an hour with you, Dr Maloney. We could spend the entire afternoon.

Just by way of a very brief preface, I want to tell you that as I read your report it was like the experience I had reading the Hall-Dennis report some 20 years ago. I am one of the people in Ontario who says that as a compliment in terms of the vision it represents about children and about a holistic approach to children. The recommendations go in the direction of my bias, which made me very comfortable with the report. But I will pose two very specific questions about implementation because I am concerned that its fate might be similar to the other report that I mentioned as we get into the difficulty of implementation.

I will leave you with the two questions. I know they are not fully answerable today. One is that, as I read the report, my belief is that your recommendations would

necessitate a very large-scale decentralization of existing services in order to be able to build around the school as a hub. I would like you to give some comment as to whether I have understood that correctly.

Second, I did have a little bit of a concern as you spoke about resources. When I was reading the report there seemed to be that sense that, if we could remove the duplication of service and ensure it was co-ordinated and effective service we are delivering, perhaps we would not need significant new resources. Yet in my understanding of the overcapacity, the demands on existing services, I really question, even if we have the ultimate co-ordination, whether we are not still going to need significant inputs of new resources.

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Dr Maloney: You had two questions. In regard to the first one in terms of decentralization and centralization, which has always been a major issue, clearly a new strategy has to be evolved. I think the best way to look at it, for myself personally, has been in the business world. The business world and the large corporations have a new sense of what is to be centralized. We need it much better centralized than we have ever had. There has to be the co-ordination, the direction, the sort of consistency that will achieve the equity that we need. It needs to be decentralized in a way that is quite different than just sort of sending it outside and having it as we do now. It has to be truly something that is allowed to be locally controlled in a way, so it is nearly a paradox.

But in terms of our new systems of information, the ability in a sense to overcome time and space through the technology that we have, a new tension between decentralized and centralized is possible. So that question is really a new question, and I think it has to be looked at, because there is a sense that we get fragmentation if we decentralize.

Yet when you look at the major international companies that I think would have at least as large an issue as we have in terms of this, they have achieved something that is radically new, something that gives direction, vision, gives a training ability, gives the responsibility from a centralized viewpoint, but allows a far more decentralized approach that allows the locality really to own what it is doing. That is the first question. I think it is a new strategy and I think we cannot go back to the questions of before.

In your second question about the money, you have touched obviously the crucial issue. From a political point of view, which you would understand, we thought it was not the most political to start off with the issue of money. I think we needed a vision first to say, "What should we do?" We had the belief that the people of Ontario will not question whether there is more money or less money if it is well spent.

We were not saying it would not cost more money. I have known of nothing in this world that does not cost more money, or very seldom. How much more? I think that would be a legitimate question to say more money, if we can demonstrate what we are doing now is well done

and done cost-effectively. I think it will end up costing more money, but I do not think that is the issue.

Mrs Witmer: I appreciate all the work that you have done in this regard. I wonder if you could expand for us at this time and share with us how you see the school as the focus.

Dr Maloney: We have in one sense made a distinction between the resources and the building that would be a focus and, as the minister has spoken, in a sense we would not, without consultation, say this could be always and everywhere the focus. What led our report was in a sense that it was to be promotional.

Our strategy in the first place was to strengthen the healthy child, and not in a way that would pick out and say, "You are sick and you need help." We are saying all children need to be supported. We look to the universal system, which is the child care system to some extent, which is still already in the school system and gave us the first indication of where to go.

Where are our children to a great extent? They are in the schools. At the same time, we are very much aware that if you ask the teachers to do one more thing, you deserve to have a revolt on your hands, because they handle our problems of child abuse, AIDS, violence and what else. They are not there to solve all the problems. We wanted a solution that would help educators to do what they want to do best, which was to educate.

Our proposal asked that the school system be asked to go in partnership so that they would be allowed to do better what they do best and not to add something more to them. Nothing would make teachers happier than when they do not have the violence, the school kids who are hungry, the kids who, when they go home, they know there is no help for them. I thought we were looking for a partnership with the school in the sense, "Where can we best grow our children?" Obviously, the school was the answer.

But we also had a very key player that should be highlighted here, the recreation system, which I know is much more a municipality system in some ways, but key. If we are to have two working parents, as the economy of Ontario demands—this province, at the present moment in our global competition, would stop if women who have children stopped working—if we are to say, "You are to work," we have to support that in a way that we do not. We know the whole issue of child care has to be raised and it has not been raised. It will need to be raised by this government, by all of you.

It is a horrible, difficult problem, but we cannot, on one hand, ask parents to be our major partners in an economic way and not support them in a family way. We cannot say we will have a school that goes two or three months and then not have school and say "You look after them," when many of them cannot. Recreation has to play a key part in that. That is why, when we saw that in many places they have that partnership with recreation, we thought that could be expanded and built upon and be far more promotional than we have presently.

I hope that got at your question. I know it is very general and vague, but that is why we went to the school system, leaving it up to the school system to say how that can be actually worked out.

Mrs Witmer: That is right, and I appreciate your comments, Dr Maloney. For years I resisted adding something else to the school system, but in the past few years I have come to recognize that that does seem to be the logical source to co-ordinate the action.

Dr Maloney: If it is just an addition, it will not work. It has to be a complementarity, a partnership that is of benefit to both sides.

Mr Martin: I am also a big fan of the Hall-Dennis report. I thought it was great.

Mrs McLeod: I did not know there were two of us.

Mr Martin: A vote from the north, eh? I thought it threw some creative, courageous challenges to us and I suggest to you that one of the reasons that it did not go forth is the resistance by the professionals in the field who either would not be or were not properly trained to participate in that. I guess, being from the north where resources are not always so readily available, I sense there is a bit of tension in some of the activity I have been involved in in terms of the very volunteer support group, the laywork of folks who support families and children in difficulty, and the professionals.

Do you have any thoughts about how we might meld that in terms of a movement forward that could be courageous and creative and yet not cost the kind of money that perhaps we may get into here if in fact we get into sending up to the north more professionals, which may not be what we need?

Dr Maloney: The issue obviously of turf, of the historical divisions that we have, the willingness to co-operate—perhaps I could take time to relate one small incident that really amazed us. It was called a consultation and it was with a cross-section of directors of schools from all over the province, and from the north also. We presented a sort of draft of directions we were hoping to go in, and basically they said, "What we have heard so far would be considered a wimpish report." That left us a bit stunned, because we were going very gingerly with the schools in a sense, knowing how much they had been imposed upon. We did not want to be seen to be demanding more than we should.

That whole section of people I think were representative at least of those who were the best in the system in some ways, and we were very clear that the direction they pushed us in was the final direction we went into. I am not sure we would have gone so bravely—not being seen as sort of, "Would you ever get this type of co-operation from the mainstream system?" became clear from that consultation. They not only expected it but said we would be failing the education system if we did not demand it.

One of the reactions I have had to the report from all systems is to the sense, "Well, in a general sense it does not get down to nitty-gritty and does not step on anybody's toes, so it is easy to be in agreement with it." But I would say there is the goodwill for that type of co-operation

much more than 10 years ago or 20 years ago, in an extraordinary way. That is why we hesitated and said it was not just—the north was one example. Not everywhere in the north would the school be the ideal situation.

I think one of the reasons we left that as sort of some options—and the minister was trying to say that—is that the north did not seem very clear to us that that was not always the best centre of the community, and we said a local community would decide that in the sense of that struggle with the north in terms of professional and the lack of it. The report really did not address that in a good sense. I think that is the one that has to be struggled with much more. Some of the initiatives they are doing now in terms of recruitment, doing it co-operatively, giving a better scientific base to things, have been somewhat successful, but I think that remains with us as an issue.

Mr Jackson: Very briefly, Colin, I have had an opportunity to read your report. It is a very good one. When you talk about vision, were you able to find any jurisdictions in North America which, in your opinion, are moving in the direction that you are calling for, that you saw some models of? Canadian models preferably since they have two school systems, which is a practical consideration when dealing with delivery arms. You talk about fragmentation, but we do have a dual system and there is some talk of a tripartite system, and certainly by language you get into four systems in this province. Can you bring to this committee's attention any jurisdictions where you saw some progress in this direction?

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Dr Maloney: We did not see this as a model which we took from any jurisdiction. It does not exist, as far as I know, in the sense we proposed. That is why it really falls into the category of vision. Whether vision becomes a nightmare in reality is always an open question, but what pushed us that way is where we put the child care. The second issue was what has happened over the years with the mentally handicapped. There is a variety in the spectrum of how that has been successful, but when it is supported, when it is resourced appropriately, it is very successful.

There are other initiatives in the United States; in Missouri, for instance, the school as a base for new mothers and their grouping together in relation to public health that is in the report. It was all those sort of streaming, the experience we have in Ontario; many cities have a contract with Recreation, and the school board and Recreation provide it. All those different elements forced us to this vision in a sense, sort of pulled it together. I think it was very much reinforced by many programs like that, to say, "Well, let's make a system that way."

Ms Haeck: I have had, as a result of my new role as an MPP, a chance to meet with a number of community groups, and most recently the local family and children's services. Our discussions and obviously some other things I have read have made me aware that there really is a fair bit of competition between a number of the centres out there, the family and children's services and the other

mental health providers. How are you addressing that particular situation?

Dr Maloney: Nothing like money brings out where the goodwill is, when you put it on the table. You touched a key point, the sense that there has to be a strong centralization of direction, priorities and bases on which things are decided. It has to be there. When it is on the table now it is a sense of who gets what. It is not seen that way; it is history or whatever it may be. You ask, "Why is this agency funded that way or why that?" It is very difficult to get a basis that goes beyond history.

So in one sense there has to be a sense of priority-setting, a sense of rationale, why things are done the way they are, which you do not have now. We come back to the very first question: there is a key role for the central administration in those areas, which does not exist now. When you run into the problem of turf, who gets what and how they get it, it becomes a political issue rather than a service issue, which is unfortunate.

Mr Beer: I do not know what status a former minister has, but I would like to publicly thank you for all your advice and the work of the committee over the time I was there. Certainly, in reading the report, if you did nothing else you held forth a vision and a sense of integration of the services we must develop to support children, which are terribly important to have out there. I would hope this committee and the work we do can build and take forward what you have started.

It seems to me that there is a question around how you are suggesting we might organize this new vision. I appreciate that the committee may have looked at some very specific models and then backed off a bit to allow discussion to focus on how we can better integrate the services, both centrally and then at the local level. I think your response to the earlier question around new ways of centralizing and decentralizing is very interesting.

Specifically, provincially, is it your own view that we will have to set up a unit—whatever we call it, ministry, secretariat—with real power that will in effect take programs, authorities and money currently being disbursed by Community and Social Services, Health, Education and Recreation; and that in a similar way at the local level we really do need to be thinking about some other kind of body? It seems to me that this is one of the elements of your report, that we may have to rethink the role of school boards to the point where in effect you would almost have a kind of children's services board or council that would be carrying out the functions of school boards as well as the functions, perhaps, of children's aid societies or of a whole series of other agencies locally.

My question then is: Do we have to have something that is very clear-cut with real power at both those levels with authority to spend dollars, or can we do this in I suppose the traditional approach, trying to have more and better co-operation, stick in a few carrots but not really change the system?

Dr Maloney: That is a very key question. I think if the committee had been practical and more political, it would have gone the second way. We had the freedom, as a com-

mittee does, really to let that be your problem, to just look at it from the children's point of view, not look at the practical sense or the horrendous problems this would raise or the people who would be out of joint because you try to change their territory.

If you start with the system, you have to end up with a sense of, "Let's move it here or there; let's do what's practical." We did not look at that. We said if you look at the planning for children, should you not look at children from a healthy point of view, and where there would be special needs, look at it from planning, co-ordinated, the best setting of priorities both in a centralized and local way. That is where we came from, that principle.

I think it is very easy to agree with that in principle, that planning should be done in a co-ordinated, holistic way. Is that possible, given what our history is? That is the challenge. I think it makes it very difficult, because the report is idealistic, it is a vision. Can you change so much? So much is involved there. At least it should be open for dialogue to see how far we can go. In the committee, obviously, that principle is easy to defend. Is it realizable politically? Can you move so many things?

I think that would depend on whether you really feel that reorganization would be helpful to education: will it be actually to the aid of education to do that? Then it makes it possible. If it is to disturb education and otherwise make it more upsetting than it is, it would be political and I think impractical. But if it is seen as enhancing the very question of our 30%, our literacy, our lack of being able to meet the standards of our economy in terms of our technical approach, if it means it allows something to happen on that, I think it may even be practical politically.

Mrs McLeod: I will again be very brief. I know Mr Martin, at the beginning of our committee's session, expressed concern that we would not be able in these few hours of hearings to address some of the very particular problems of northern Ontario. I totally agree with him. I was very pleased to see that your committee made a special effort to look at the problems of northern Ontario. Just so it is recorded from your report and into our record, you note that northern Ontario "consistently exceeds by factors of two to four times the province's suicide rate, infant mortality rate, illiteracy rate and rate of children taken into care."

My question is not answerable in the moment left, but did your committee have some sense of the way in which the particular needs of the north could be responded to and, if so, can we invite you to come back at some time to tell us what those responses should be?

Dr Maloney: You can invite me to come back for the responses. Obviously, this was a very, very complex issue and very difficult. There was no simple answer to it. We dealt in the report in generalities. You are basically dealing with an issue in terms of resources, poverty, distance and all those things, but to a great extent poverty. To say that there is one simple strategy to approach that made it impossible to deal with in our report, I would be glad to talk on that any time you want, because it deserves much more attention than that.

The Vice-Chair: We have run out of time. We would like to thank you for making this presentation. We hope to hear from you in the future as well.

Dr Maloney: My pleasure. Thank you very much.

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ONTARIO ASSOCIATION OF CHILDREN'S MENTAL HEALTH CENTRES

The Vice-Chair: Our next presentation is from the Ontario Association of Children's Mental Health Centres, Alex Thomson and others, I believe. Sheila Weinstock is also with you.

Mr Thomson: Sheila is the executive director of the provincial association which we represent. I would like to thank the committee as well for this undertaking. I would like to thank Mrs Witmer for bringing it to your attention. It is most helpful in terms of our ability to express our concerns to the government of Ontario and the public generally about the issues which are facing our association in our attempts to provide quality mental health services to the children and families in this province.

You have received by this time, I think, a copy of our brief. My intention is not to spend time walking you through that brief but highlighting some of the critical components from our perception. Then, Sheila and I are more than prepared to dialogue with you around some thoughts and questions you may have.

I will take about 10 minutes to highlight some of the concerns and issues we have raised for the better part of the last year. We are 85 children's mental health centres across this province, funded for the most part by the Ministry of Community and Social Services; in some situations, some dual responsibility with the Ministry of Health as well.

Our provision of care to children and family falls in generally three areas. We provide it on an outpatient basis; in day treatment processes and programs, which is essentially, in some respects, alternative to school programs with a psychosocial component to them; and 10% of our services are provided in residential services. So you can see the vast majority of our programs are provided in the least intrusive programs possible.

In 1989 we served 50,000 children across this province in those 85 centres at a cost of approximately \$166 million; it averaged out to about \$3,400 per child.

In 1989, we undertook a major effort to try and understand globally the pressures that were coming to bear on the 85 centres across the province. We understood at that time that we had approximately 10,000 children waiting for services in our particular centres. Some of these children, on average, are waiting six months to two years for that service. In some of those situations, it is a tremendously long time for those children to wait. The practical fallout of that is that the children who have to wait up to two years for service may only need the least intrusive service at the beginning of their wait, but by the time they get to the door they may need the most intrusive service. That is what brought us to the point of raising this with the government in a public forum. It has been a major concern to us throughout this last year and a half.

There are basically three points I would like to raise with you, and we also have some suggested solutions. The first and foremost point is the issue of access. We work from the principle, under the Mental Health Act, that children and families in this province should have a reasonable access to service, particularly mental health service. The difficulty with access, as I described to you, is the number of children waiting for service. It is exacerbated by the fact that those approximately 10,000 children, in many cases, we are unable to truly diagnose or assess because they are literally waiting for even that component of our service. There might be a single page of information, which really does not help us truly understand the needs of that particular child.

In keeping with the Maloney report, last year we requested the government to undertake a broad global review of the issue of children's mental health beyond the confines of the Ministry of Community and Social Services, on the basis that we too believe that the Ministry of Education, the Ministry of Health, Comsoc, Corrections, Recreation—I think Mr Maloney and his committee have broadened the stroke somewhat. We are not in disagreement in principle with those issues, but what is brought to light is that here is another committee that recognizes that there is a broader context than just children's mental health centres providing this service. We advocate for that, we advocate for a better co-ordination and identification of the true responsibilities of all those actors in the progress we need to make with our children and families in this province.

We also have some difficulty with legislation. We believe there is not effective legislation to address the true needs of children who are afflicted with mental health problems and their families. The legislation is narrow. It does not allow for truly co-operative ventures between the Ministry of Health, the Ministry of Education and the Ministry of Community and Social Services, and there may be other actors as well. We requested then and we request now that there really does need to be an absolute review of the existing legislation, a broadening of its ability to practically deliver the services necessary.

Probably the most delicate issue that will be undertaken or reviewed throughout your two days, and hopefully the government's review of this in a much broader context, is the whole issue of resources. Mr Maloney before us indicated that the report is not a panacea. The report in principle has some very solid foundations, there might be many ways of its practical delivery, but do not go into it thinking that the problems will go away as a result of just basing it with a school-based program as its focus. There still will be a need for professionally trained individuals to assist those children who will continue to fall through the gap. There is no question that Mr Maloney's committee's report begs the province once again to truly look at preventive situations and preventive processes, and there is no disagreement with that. The more children we can provide a solid foundation for, the better off in the long run we are going to be, but there will continue to be children who will require assistance that is above and

beyond what is normally required and provided for children.

This brings us to our particular issue in terms of resources, and that is the issue of human resources. We are a sector that employs 5,000 professional people whose mandate is to try and assist children who are beyond the normal ability to repair themselves or work through less intrusive programs. We are a system that has been under the gun in terms of staff turnover, in terms of our inability to attract and retain qualified staff to our sector. These figures are not new: in the central Toronto area alone, when we compare our non-profit organization's ability to pay professional staff compared to ministry-run operations, we are 40% behind in salaries. It does not make us very competitive. It makes our job a whole bunch harder. Across the different sectors, we are looking at a 28% differential with the ability of boards of education to employ social workers, psychometrists and psychologists. With the Ministry of Health we are a little closer, but we are still 15% behind in salaries.

What happens practically for us is that we begin to become the training ground for professionals who work in those systems. If you follow the logic of the Maloney report—I am not lambasting it; I have read the report as well, and we will respond to it; I think there are a lot of good principles in it; I do not agree totally with some of the practicalities of the delivery of that. But if you follow that line and you put specialized services hooked into boards of education, you are going to have face that music somewhere. You cannot employ specialized services, social workers who might be employed at children's mental health centres but linked to a board of education, and have social workers within the board of education who are paid 28 per cent higher. It will not fly.

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That is again a critical issue for you as members of the government and the Legislature generally to struggle with. That problem is not going to go away, unfortunately. It does mean that we are concerned about the quality of service that we are mandated. Our share of the workload in this province is to deal with some of the very difficult children who fall out of boards of education, who fall out of other systems, and we are in a situation where we are employing a lot of young, inexperienced, although paper-qualified people. We are training them only to lose them in a few years to Education, Health and other job and career opportunities. You cannot say anything against these people because it makes sense, if you are in those positions, that you can earn more than in others to do the same job and hopefully, in effect, achieve the same goal of helping and assisting troubled children and families, and more power to them. That issue is a critical issue, no matter what path this government takes.

What we suggest as a resolution is that we would like to see the government now take and develop what we would call, at this point, an action-oriented implementation task force whose membership would be made up of Ministry of Community and Social Services, representation from Health, Education, Correctional Services and possibly even Recreation, the Sparrow Lake group, the various

provincial associations that would have interest in these services, including ourselves and the Ontario Association of Children's Aid Societies, Ontchild, which is a very similar organization to ours, and consumer representation. The task and role of that task force would be essentially to take the responsibility for investigating and developing some long-term and medium-term solutions to real inter-ministerial co-ordination.

We have been in a process for a year and a half with the past government. We have been involved and worked co-operatively with the governments of the past in their interministerial committees to no avail. We have not seen any real work come out of that. We are asking you to take a look at putting together a team that would be responsible to the public, the actors who are responsible for the provision of service and your membership—members of the government, members of the opposition parties—who would be able to act in a concerted effort to really look at possible solutions to how we can better communicate, how we can free up the different organizations to bring the resources that need to be brought to bear. Co-ordination of services at a local level is certainly in keeping with our own thinking.

I would like to respond to Mrs McLeod's question—maybe it was Mr Beer's; sorry, I was sort of reviewing my notes over in the corner—about whether or not a central authority at the local level is the answer and whether we should do it on the basis of a co-operative venture rather than power-based. I would go for the co-operative venture, and I would beg you to go to Hamilton and look at the Association of Agencies for Treatment and Development system, which has been around for 17 years. I made a presentation to this committee five years ago about that system. I talked to the former government about that system. It does require resources, but it is a co-operative venture that works, and all the actors whom Mr Maloney talks about are around the table and work on a community basis in the development of the provision of services. You might want to take that look-see in terms of that option.

An appropriate funding formula for locally based decisions so that each community has appropriate standardized services has been one of our issues, one of our concerns. The legislation does not guide and provide guidance for the standardized availability of services across the province. Much of that is dependent upon the local area office and some very local bureaucratic decisions that can guide whether or not you have children's mental health services or whether you have more CAS services here or whether you have something else. There has to be some review of that so that there can be some standardized ability for the government and local communities to provide minimally standard care in a spectrum of services in each local community or region, however you define that.

We also think that this committee should look at some of the legislative issues in terms of some of the real changes and not restrict it to the Child and Family Services Act. There are issues that go beyond the CFSA. It has implications in terms of the Education Act; it has implications in terms of the Mental Health Act as well.

Our last suggested responsibility of this committee might be, in keeping with Mr Maloney's report, to look at that whole issue of children's authority and local planning. We are firm believers in that. I do not know at this point whether that is the true answer, but that is an opportunity to begin working towards that immediately.

With regard to the tougher questions from our perspective and tougher questions from your perspective, we have some very immediate needs. We do have the same approximate number of children on waiting lists. We have not completed our second round of reviewing that list, but the numbers that are in are telling us that has not changed. We have a serious number of children, a large number of children who are waiting for service. We need some immediate assistance in this budget year to begin, as I said earlier, to even look at those kids and try to find out which of those kids are the most urgent kids and we can then begin to try to address those issues. As it stands now, the children wait, without our even understanding what they are waiting for or how severely disturbed and difficult they are. That is a major problem, not only for us but for this province. Those are the kids who are going to end up in adult institutions eventually unless we begin to address those issues. That problem has not gone away.

The other immediate request we have for the government and this committee to review is some assistance in terms of the wage issue. The previous government had taken some steps to look at some compensation adjustments for direct child care workers. That is most appreciated. We are in the throes of undergoing that. We are not sure how far that is going to go, but we do have further needs beyond direct child care workers. We have to look in a broader context.

We all are faced with practical issues of pay equity. Right or wrong, many of our non-profit organizations have been in the same fix that other organizations have been, where we do have situations where we do need to make pay equity adjustments. That money has to come from somewhere. Otherwise, as non-profit organizations, we are faced with making tough decisions like cutting service so that we can make pay equity adjustments and having only 30 people employed rather than 40 and serving only 300 kids rather than 400 kids. Those are real situations for us and we need some assistance with that part.

That is my presentation. Sheila and I would be glad to address some of your questions.

The Vice-Chair: Thank you. I will start with Mr White.

Mr White: I have a couple of points. First off, I would certainly agree with you about the money issue, having worked in children's mental health centres in the past myself. I am better off in even my present job. I know in our area we have just started a children's service council, I think effective tomorrow. The impetus behind that came primarily from the local children's mental health centres, of which there are some six or seven, and probably the complaints from consumers about co-ordination of those efforts. I am impressed with that. You mention that as an issue here. But I am also impressed with the list here of

how difficult it may be to co-ordinate services when I look at this list, or I do not know how many pages, in your submission of basically issues that revolved around some issues of pathology.

1500

They seem to be identified primarily from a medical or psychological perspective. There is very little reference here to some of the psychosocial phenomena that I have experienced as a social worker in children's mental health centres. I do not recall ever having worked with a child in a residential setting who was from an intact family, and of course most of the children I worked with were poor and often from slum areas. None of that seems to be mentioned here at all. It seems like because of the parameters of funding, the medical history, there seems to be somewhat of a limitation. I am wondering if that is something which you would be aware of or could share with us.

Ms Weinstock: Perhaps I could respond. The list that you have is a very succinct, brief description of some of the case histories, a list that was developed in the Windsor area. These certainly are not intended to be the only factors, but they do give a flavour of the complexity of the problems. I think the issues that you have raised exist and they only serve to further make each of these cases complex. That is why children's mental health centres require a kind of multidisciplinary approach, so that we can have the perspectives of the psychologists, psychiatrists, social workers and, where necessary, speech pathologists and others, who can look at the various factors and identify which is the most important in any one specific case and what is the best way to proceed.

Mr White: As a supplementary to that, certainly the research which we have—what Dr Maloney spoke of a few moments ago, Dr Offord—speaks to psychosocial issues as being predominant in terms of the genesis of children's mental disturbances or emotional disturbances. Yet we have a profound difficulty, because if the orientation is primarily medical, as seems to be reflected here, it is going to be difficult to deal with issues of children who have been witness to violent events, as Mrs Witmer has reflected in the Legislature: children who come from broken homes, where that has been the issue that has caused them the most disturbance. It does not seem to be reflected in your list of symptomatology.

Mr Thomson: I think you should accept the list exactly as you described, just symptomatology. It is not a reflection of the narrow focus of our ability to provide service, by any means. We are much broader in terms of the skills. One of the mandates of the membership of the association is that it is a multidisciplinary approach, including teachers.

Mrs Witmer: I would like to express my appreciation to you for the information that you have provided for us today and also during the election. I appreciate the lobbying that you have been doing on behalf of children in this province who are so neglected and who are falling between the cracks.

You have recommended here the creation of an independent task force. Do you see that task force working

co-operatively in planning for and implementing changes and new directions for children's mental health services? Once that is done, do you then support the development of a local children's services planning advisory authority in order that, as Mr Martin has indicated, there is a need to address the local needs in a community? I think, as well, Dr Maloney talked about the need for centralization, but also decentralization, because there are unique needs in each part of the province.

Mr Thomson: Personally?

Mrs Witmer: Yes.

Mr Thomson: I come from a very unique community that has had local co-ordination for 17 years. I have been a participant, and a successful participant. There are very few changes that happen in my organization without some vetting at the community level. "What would you guys think if we did this?" The power rests with the individual organization, but you basically go to the table knowing that you have a responsibility to all the other actors, as they do to you. That has been built up over time.

That formula may not work in all communities. In terms of a co-operative local venture, yes. Whether it is as Dr Maloney has suggested, I cannot answer that. We have only received the report as well, and I cannot speak for the association by any means. In terms of co-ordination of services at the local level, yes. Beyond that, though, there has to be some standard ability to provide certain levels of care in each and every community. That is the responsibility of the government and the province of Ontario. So if that answers your question—there are two tiers to it, as far as I am concerned.

Mrs Witmer: Just as a supplementary, I sense that perhaps you had some hesitation about the schools becoming the central focus, and I guess I would like to ask what your reservations would be. I think it is important that we know that.

Mr Thomson: This is my personal opinion. The association has not taken a position on this. It is based on my experience in Hamilton that whenever authority comes into play between organizations, then politics gets played and power plays get played. We work co-operatively with the local ministry's office, which is a participant in that process. It seems to work. That is all I can say.

That is my hesitancy. I would not want to see a super-board set up to control and have authority in all those cases. I think it is too broad a mandate in that respect. I think you have to have some specialization even at the local level, and boards of education know what they do best. But when they fail with a child through even their own special education systems, they also know it is best to rattle that child out to a children's mental health centre which has some specialized ability to assist that child. That mix still has to be there.

Mrs Witmer: I would agree with you, by the way.

Mrs McLeod: Two questions. First of all, very briefly on that, you mentioned the waiting list and your sense that those waiting lists continue to be about the length that you felt they were when the original review was undertaken. May I ask whether or not you have a sense whether the

rate of referral is less because the referring agencies or individuals are aware of the waiting list and the referrals somehow, therefore, become less relevant because the treatment or the intervention is not going to be available when the problem is most acute?

Ms Weinstock: I can certainly respond to that in that this year we have received a number of responses to our survey saying that some centres have stopped collecting waiting lists and that people in the community are aware that they are not going to be able to be seen and therefore they are not referring. So there is some of that.

Mrs McLeod: I continue to believe that something we have to look at along with the waiting list, which is obviously a concern, is the referring source and how well the service is addressing the needs of children at the referring source, which brings me to the second question, which is essentially a follow-up of the one that Mrs Witmer just asked.

I am going to take 30 seconds just to tell you my bias. I had an opportunity to work in a somewhat aberrant situation with a children's mental health unit in a hospital setting, where I was not restricted by the clear delineation of what was the role of the school practitioner and what was the role of the mental health practitioner. My concern became one that the referring source had to be able to diagnose the problem before it knew where it should be dealt with. If it was a mild behaviour problem it could be dealt with by the school, if it was more moderate or severe it had to be referred to the children's mental health centre.

My perspective may be biased by coming from a northern community where the resources are limited and where we do not see duplication, we see almost a fragmenting of the child. It is difficult to frame the question briefly and ask for a fairly brief response. Do you have a sense that there is in fact duplication, or do you sense that the co-ordination of what existing agencies are doing is necessary so that we can bring all those resources to bear on the child without that separation of the types of intervention that are needed?

1510

Mr Thomson: I think there is bound to be some duplication in any system along the way. I do not think that what you will see in real terms is absolute duplication, where someone would put a child on the waiting list and continue to provide service. Children who get referred to children's mental health centres tend to have used up all the usefulness of other, more normative services, so they are coming to us with real problems that cannot be dealt with in the system, whether it is education or the children's aid society or wherever. I do not think there is a tremendous amount of duplication in that sense. Does that answer your question?

Mrs McLeod: It does in part. Let me try to be a tiny bit more specific. Do you find that children's mental health centres in the province are able to do any learning disabilities diagnosis, for example, where there is a sense that perhaps that is an underlying problem? I do not want in any way to negate Mr White's comments about the further underlying problems.

Mr Thomson: If they happen to have a working psychometrist in their system, then they may be readily able to and they may have to wait even for that service. I know for a fact that in Hamilton we do employ a psychologist on a consulting basis at my centre. We pay him on a fee-for-service to do those.

When we go to the school board, when we are working with a child, for instance, who is in school, and at Lynwood in residence, by example, and we say we need some psycho services to this child, we will wait six months for that in the board of education, so we will go out and purchase that service. That may be duplication in that respect, but they are not a priority of the board of education at the moment because they are not really there yet.

Ms Weinstock: If I could just respond briefly, as well, Mrs McLeod, there are some bureaucratic difficulties to children's mental health centres being able to respond, for example, to children with learning disabilities. The issues you have raised really are the reasons we are so clear that this needs a multiministry response. There are programs coming out of hospitals, even though the Ministry of Health says it has no responsibility for children's mental health. There obviously are programs for troubled children in the schools, but because we are pretending it is only in one place, it seems very fragmented. We really need a multiministry approach to bring all those resources together and create a coherent plan.

The Vice-Chair: I hate to interrupt, but we have one minute left. Mr Owens would like to ask a very brief question, and then we have to proceed.

Mr Owens: Where is your pay equity process at this point and approximately what kind of dollars are we talking about and extra resources being required to fund that process?

Mr Thomson: I am sorry. I cannot report to you about the whole association and in what position each organization is in terms of pay equity. Some have completed it, others are in the midst of it and some are just beginning to tackle it. I suppose. It depends on the organization.

What I can tell you in the broadest context is that if we took some very exacting information that we have received from 33 centres of our association that operate in the Metropolitan Toronto area, these figures are not related directly to pay equity, but they relate to their equivalency in comparison to direct-operated entities like Thistletown. We are looking at approximately \$9 million in that area alone for 33 centres to make the adjustment and make the jump to equity and comparable salaries between non-profit organizations that are run by voluntary boards and the ministry-operated system. What you might find there, Mr Owens, is that there is probably a fairly direct link between pay equity adjustments and equity adjustments in that many of our organizations are under the gun to be designated as having the ministry as the employer, because we do not have true comparatives in some situations in our organizations.

The Vice-Chair: I would like to thank you for your presentation, which was very succinct and interesting. I am sure it will further our debate.

I hate to rush like this, but we do have a very strict time line and we will proceed to our next set of presenters now. Those members I did not get on in the previous sequence I will try to bump to the next sequence in terms of order of presentation. Please bear with me. I have to follow this procedure. Mr Martin will be next in terms of priority on the list for questions.

BEECHGROVE CHILDREN'S CENTRE

The Vice-Chair: I call on the Beechgrove Children's Centre from Kingston; Phil Ogden is the director. Thank you for joining us. You may proceed. I remind you that we have half an hour for your presentation. If you would like to allow time for questions, you can split that up any way you like. Usually it would be 15 minutes and 15 minutes, or however you would like to proceed.

Mr Ogden: Thank you for the opportunity to present some of my own personal views. My background—just a little so you know how I arrived at some of these opinions—is that I have been in the administration and planning of children's mental health in Ontario for the past 18 years at various levels. I have also been a Ministry of Community and Social Services planner in a regional office. I have worked for four different agencies. I worked for one of the ill-started local children's services committees back 10 years ago. For the past eight years I have been executive director of one of the largest centres in Ontario, the Beechgrove Children's Centre. So that is how I come to some of these observations.

In spite of substantial increases in the global funding of children's mental health in Ontario over the past decade, waiting lists, as you have heard, continue to grow. The mental health of this child population appears to be deteriorating and those children with psychosocial problems seemingly are more disturbed and disturbing. This is not only noted by children's mental health centres, but I am sure that if you have educators appearing before you or people from the child welfare system, they will all tell you exactly the same thing.

Just let me say that you are going to hear some comments from me that probably will parrot some of the others. I did not get together with them. I did this independently.

I think it is time to closely examine how our society is contributing to or creating these problems, to re-evaluate whose responsibility it is to intervene with these problems and to re-examine strategies for both the promotion of positive mental health in our children and families and the provision of treatment and rehabilitation services.

With the substantially broadened public definition of children's mental health—here I want to digress a little bit. I heard a question previously from one of the members of the committee about how narrow is mental health. Well, let me tell you, for most of our centres I do not know where the boundaries are any more. What is not mental health?

Let me tell you that we have problems with behaviours in home, school and community. We have conflict in families. We have inadequate parenting, delinquency, drug abuse, family violence, physical and sexual abuse, learning disabilities, hyperactivity, truancy, school and parent con-

flict and non-compliance, as well as the medical conditions that were specified in the document.

So we get the full range, and I think that is true of every centre, and it is hard to tell any more what is not mental health as far as the public demand or the professional demand is concerned.

With a substantially broadened public definition of children's mental health and with the increasing stresses on children and family life, children's mental health becomes too important and demanding a topic to be left dangling visionless between two ministries. It is far too large a problem to be left to the 85 children's mental health centres funded by the Ministry of Community and Social Services, plus the 20 or so clinics funded by the Ministry of Health.

No legislation exists in Ontario—you have heard this before—that entitles children with even the most severe mental health problems to services. There is no guaranteed access, even no directive access. There is no entitlement for even the most severe problems. For life-threatening emotional problems, few communities have any designated centre or protocols for responding to children under 16 years of age.

1520

Just one quick example: This is unique only to the extent that it happened very recently in our centre, but this could be played out many times a year across the province because of the split in jurisdiction between the two ministries.

We see about 1,500 children a year, about 110 of those in residential treatment, the rest on an outpatient basis at our centre. We rarely need and require medical assistance. We do not cry wolf. We handle extremely difficult suicidal cases every day of the week, every day of the year and so we very seldom insist on medical backup.

We had a girl who had a lifelong history of abuse, a very disturbed, very disturbing girl, a very acting-out girl who once in a while would lose it and have a psychotic break. She was in our residence and this happened. We held her, held on to her, used manpower, used all our skills for about six hours before we called for help.

Meanwhile, she assaulted and quite seriously injured a couple of our staff. So we went through our list of possible psychiatrists in the community so we could sedate the girl. We made seven phone calls over a couple of hours. Nobody responded. Nobody could free themselves up. It was not their problem; it was our problem.

We finally, with police help, took her down to the emergency ward at one of the hospitals, which is actually quite close to our centre, and there was all kinds of political bureaucracy and reasons why they could not see the girl or should not see the girl, and was it not our problem?

It was not until the doctor said, "Police, accompany the girl into the room," and we said, "We don't think that's such a wise idea; we'd better stay with it," and he said, "No, I can handle it," and the girl proceeded to break free from the police and bang her head on the floor until she was all bloodied that they finally came around that they had to do something about sedating this girl.

That is just one example. It was an extreme example, granted, but those kinds of things happen every day somewhere in the province of Ontario because of the split jurisdiction between the two ministries.

As I was saying, hospitals and children's mental health centres in many communities are able to evade responsibility for these children by laying blame on the opposite system. I have just done that myself, because we have been trying to get a full-time psychiatrist for about a year and a half, and we cannot recruit one because they do not want to work in our system.

Government policy does nothing to clarify these situations. In fact the lack of co-ordination between the two ministries sets the tone for this evasion of responsibility.

No standards exist within the ministry exclusively for children's mental health centres. There are some general standards in the Child and Family Services Act applying to all programs funded by the ministry, but again, there are no standards explicitly for children's mental health centres. I would say there are some differences between children's mental health centres and other sectors funded by the Ministry of Community and Social Services.

I am personally unaware of any individual in either ministry who has both extensive experience in and substantial responsibility for children's mental health issues. Currently within the Ministry of Community and Social Services there is a push for amalgamation of children's aid societies with children's mental health centres, without any discussion of the implication for clients of obscuring the line between mandatory and voluntary services. It seems to this observer that such blurring of mandates will lead to even further loss of power by disadvantaged families or those experiencing severe psychosocial problems.

We find in our centre when there is a lot of pressure on the family or on the child to engage in treatment, either from the education system, from the family doctor or from the children's aid society, that it is almost the kiss of death for therapy. It is very difficult to do that. Granted, children's mental health centres have to become much more innovative in how we hook or bond with resistive families, but you cannot force them into treatment.

Mental health workers are demoralized by the perception that their efforts are not valued by the ministry, indeed the perception that many within the ministry have a welfare perspective which is anti-mental health. I say that is a perception but perceptions become reality.

It appears to many of us that the ministry, in its genuine attempts to hold down costs and make services more accessible for the disadvantaged, may be attempting to reduce quality to the point that effective intervention with difficult clients will become impossible. However, I would like to commend the Ministry of Community and Social Services for its recent funding and innovation in Better Beginnings, which looks at a long-term perspective for community prevention projects in mental health. I think they are to be commended for putting that in the funding mechanism and making that available to various communities.

Children's mental health agencies—we are not without problems either in spite of substantial changes over the

past decade—also continue to lack the data, the consensus and the vision demanded by Ontario children's increasing psychosocial problems. We often are too parochial in our age or problem criteria for services. Many of our agencies are too small to cope with the myriad administrative community and clinical problems in any cost-effective way.

I think there has been some reference made to the thousands of agencies that Comsoc funds. Just let me insert here that in one of the communities that we serve, and we serve a six-county area, you can go up the main street of town and you can find—now, there are not children's mental health centres, but there are various programs funded by the Ministry of Community and Social Services. It is something like 16 different offices on one street. I think that is crazy, and all these are agencies of 6, 8, 10, 12 people. It is not cost-effective.

Few of us have the time or the incentives to closely co-ordinate our services with those of other children's mental health agencies. I am glad that Alex gave you one glaring exception to that. It is terrific what has been accomplished in Hamilton, but many of us are not doing that.

Never mind co-ordinating with those of other children's service sectors. Some of us continue to provide expensive long-term residential treatment without the data to support clinical effectiveness, many times because no programs options for these children exist. Again, few incentives exist to encourage children's mental health centres and children's aid societies to work together to create less expensive alternatives.

There is a lot of turf war between the two sectors. It remains easier to lay blame on the opposite sector for failure to provide or fund these options than it is to do something about it. Many of our mental health professionals continue to engage in expensive long-term relationship-based therapies instead of focusing on shorter term, goal-directed interventions and skill development and arranging volunteers or paraprofessionals to build supportive relationships with needy families or children.

When the demands of clients, waiting lists and organizations monopolize our attention, many clinicians do not take, unfortunately, the time to keep abreast of research literature that can improve service delivery effectiveness.

Well, what can be done? I would like to table my own observations. I did not know that Dr Maloney was going to appear just before I did, or two before I did, but I would like to bring to your attention several highlights of that paper that I agree should be studied closely.

I think we have to establish entitlement to children's mental health services if even for only the most severe problems, establish a single entry point in each general community for families and children experiencing a whole range of problems or a variety of problems—one point of entry—and increase the capability of schools, public health nurses and family doctors to serve more effectively in prevention areas, early identification and as entry points for more specialized services.

Public health nurses are already doing some mental health prevention with families. I think if we increased their training and the mandate, they could even do a more effective job. Schools with positive mental health environ-

nents can act as powerful prevention programs. There is evidence that a school with a positive mental health environment can inoculate, if you will, some children otherwise at risk of psychosocial problems. Conversely, schools with negative mental health environments can exacerbate problems of at-risk children and even put some otherwise stable children at risk for psychosocial problems. Schools can make or break a lot of children and their problems.

1530

Schools should become long-hour—by that I mean 7 am to 10 pm—year-round community centres, housing integrated recreation programs and, in many cases, day care and health and social services. Schools should become visible alternatives to hockey arenas or hanging out in shopping malls. Schools must become places that parents and families consider their own. I think most schools are not at this stage.

Establish one provincial authority for children which has broad policymaking authority. Delegate to community bodies full authority and latitude to implement an integrated service system for children and families under these provincial policies.

The last one I would like to emphasize from the Colin Maloney report, *Children First*, is establish a unified family court with jurisdiction for all issues where the welfare of children is at stake. That would include custody protection, child support, all those things.

Some other recommendations you probably heard and will hear again, but these are my own:

Mandate the establishment of an outreach crisis service for children and families in every community of at least 20,000 population. These will deal with severe family conflict, threats of self- or other harm by young people and severe emotional crisis, which could release stress on some of the children's aid societies and schools.

Have an objective body review the wisdom of blending, be that co-locating or integrating, mandatory services such as child protection or young offenders with voluntary services such as family support, children's mental health, day care development services, etc. My own observation is that this review needs to be done external to the ministry; it needs to participate, but it needs to be external to it.

Give someone the clear mandate to provide mental health and support services to 16- to 18-year-olds. A particularly pressing need is supervised independent living for those unable to live at home because of abuse or chronic and severe family conflict.

Implement at least one of the recommendations of the Provincial-Municipal Social Services Review Committee, that of the province assuming full funding responsibility for children's aid societies. Child protection, in my opinion, is and should remain a provincial funding responsibility entirely. I think it is too important a matter to be influenced by the resistance of a municipality to increase in its yearly budget, and that sometimes happens. Talk to any CAS director and he will tell you that sometimes enters into the decision of whether to place a child or not.

Research literature shows principals to be a key factor in the positive mental health of a school and its children. Have the Ministry of Education establish criteria which

would include such a criterion in the selection of principals. It is time that any educational personnel who are into power and control and who do not like children be weeded out. There are some; they should not be promoted.

Work towards establishment of a continuum of mental health services in each general community. A continuum would ideally include prevention, early identification and intervention, outpatient treatment, intensive crisis counselling, day treatment, therapeutic foster homes, therapeutic group homes, residential treatment, and inpatient hospitalization for those in imminent medical plus emotional danger only in the latter case.

Establish incentives for pilot integrated programs between service sectors; eg, children's mental health and boards of education. Honey always gets you more than vinegar. Try some incentives. I see very few incentive programs around the province today.

Low-cost accessible recreation programs, and here I am parodying what Dr Maloney has said, are also vital in the prevention of mental health problems and delinquency, particularly for disadvantaged children. Many smaller communities lack these, and frequently welfare children are left out of increasingly expensive rec programs. Community development efforts in recreation should be funded by both local and provincial government. These would attempt to develop inclusive, low-cost, adaptable rec programs at the grass-roots level.

An observation is that many of our municipalities fund hockey arenas. Most children do not play hockey. It is really only a small number of children who can play competitive hockey. The vast majority of children are left totally out of recreation programs in municipalities.

Focus public attention on what is known about media violence and its increasing effects on children and families. Much work, and I would point you to Goldstein in New York, is now showing strong linkages between prolonged exposure to media violence and an increasing propensity of some of our children to use violence as a way to resolve problems. There is a lot of information on that and I would encourage you to focus some attention on that.

Thank you for the opportunity to present to this committee some of my own views. They are not the views of anybody but myself, and I would try to respond to any questions you may have.

The Vice-Chair: Thank you for your presentation. We will turn our attention to questions. I have several people on my list. Would you like to proceed, Mr Martin?

Mr Martin: Let somebody else.

The Vice-Chair: I have Mr Malkowski, then Mr Beer and Mr Hope.

Mr Malkowski: Thank you for a very impressive presentation. I appreciate getting more and more background information to help me better understand the problems. You were saying there is no standardization for children who require services from mental health centres. What do you feel should be considered in terms of standardization? What would be a priority? That family support services be provided? Do you feel that mental health

workers need further skills? What would you like us to consider in terms of what kind of standardization would be required?

Mr Ogden: I think that almost all the studies in Ontario, community studies by district health councils, children's services committees, planning groups, have identified crisis as the single biggest gap in most of our communities. That is where I would start, a crisis service that has an outreach capacity into the community, into schools, into homes, coffee shops, wherever. That is the place I would start. Then I would try to build an integrated system, a continuum of services much as is in my documentation here. Certainly there is a need for more outpatient counselling, there is a need for more integration, but crisis is at the top of my list, and I think you would find that in most communities.

The Vice-Chair: We have less than 10 minutes, so one question from each party and then we will have to proceed from there.

Mr Beer: Thank you for your paper. I think it is all the more valuable for being personal and also reflecting the broad experience you have had in the field. One of the things I was interested in was that I do not suppose anybody could serve as Minister of Community and Social Services without recognizing very quickly that he or she never had enough money to do all the things he wanted to do. It seems almost in every way that you are drawn back to: Can we organize the system better to at least make the dollars go farther? You raised some areas where you wondered whether we could have this better co-ordinated.

In the late 1970s, George Thomson and his group—Keith Norton, I guess, was the minister then—came in with the major changes at that time to the whole children's services system; very good changes they were, too. One of the things that a number of people have since wondered about is the fact that the children's services councils were not mandated; they were left as optional. You noted that you had worked with one that moved on from being optional to disposable. When you look at co-ordinating at the local level, we heard from Alex about the one that functions in the Hamilton area. My brief experience was looking at a number of different co-ordinating groups, some of which worked better than others. Is it your sense that what we are going to have to do here is not to tell the local area, however defined, precisely what it has to do but that we are going to have to mandate some body with the responsibility, if you like, to bring everyone together? Because it seems to me if there is not something like that, then what happens?

1540

You mentioned the proposal that children's aid societies and children's mental health societies become one and the same. How do we go about getting the kind of co-operation and co-ordination at the local level if we are really going to make that work, and use the resources, limited as they always will be, to the best extent? What is your advice after a number of years in this area?

Mr Ogden: I have wrestled with that one a long time myself, but I am not perfectly comfortable that I have

concluded for myself the best direction. However, on balance, I do believe you have to have a clear vision provincially with general policy emanating centrally. Then I think you have to turn it over to the local community to figure out how to implement that. While it worked very well at Hamilton and in a few communities it worked very well, as far as I know that took about 10 years to build. That may be the best way to do it, but I do not think we have 10 years. I think we will have horrendous problems if we wait 10 years, and there is a lot of communities that have not even started. I would personally give a mandate for that kind of authority to a local body.

The Vice-Chair: We have to go on. The next question is from Mrs Witmer and then, if we have time, Mr Hope.

Mrs Witmer: We have heard today from the minister and from Dr Maloney that some of the causes are poverty, single-family homes, divorce and unemployment. You mention here that we should be taking a look as well at media violence. Have you personally seen this having an impact on children in the community you serve?

Mr Ogden: It is impressionistic and not scientific from my perspective, but we run into that all the time: in my opinion, sometimes it is enough to push over the kids who are unable to separate reality from fiction and kids who are borderline anyway or who have a lot of stress. Even more insidious, I think, is the solution of violence even for normal kids. They see it over and over. I really would encourage this committee some time in the future to have Dr Goldstein up to talk about his research and findings. Even though it is from the United States, there is a lot of food for thought. It is frightening the kinds of stuff that he is finding about media violence and how it has affected kids.

Mrs Witmer: What type of action do you see children taking as a result of what they see on TV or read about?

Mr Ogden: At the most innocuous level, they try things they see: kickboxing, jujitsu, things they see on World Wrestling Federation. They try that on each other in a playful way and sometimes that can be destructive, but in a less functional, more dysfunctional way you see kids resorting to violence very quickly. They have not seen role modelling of other kinds of ways of solving their problems, but they have seen many instances on TV and sometimes in their own families of the way to resolve any kind of conflict, any kind of disagreement. It is to resort to violence, so we see kids very quick on the draw to resort to violent actions.

Mr Hope: To be very quick, without a long speech, most of your reference in here deals with welfare. As a person who has represented working people for the last 13 years, we have those who are called the working poor, with both parents out working; the child is now the victim of the so-called social depression that has now set in on an individual. Maybe I am not clear on where your terminology of "welfare" comes from. Does it mean just the status of the income coming into the home, or the status we all are faced with now, called welfare as general assistance?

Mr Ogden: My response is that by "a welfare mentality," it is doing things to people. That is the concept I do

not want to have us perpetuate. I want us to do things with people, together. I do not want to control people. Unfortunately, much of our legislation is into control rather than understanding the problems and coming to grips with them. I do not want children's mental health centres to get into that mode of agents of social control. I think we are supportive agents and that is where we should stay.

Mr Hope: You see the parents fearing to come forward with a mental health problem, "not my child," because of the lifestyle they may have come from? Is that still part of what happens?

Mr Ogden: Children's mental health is still stigmatized. Mental health is still stigmatized. By the growing definition, I think more people are willing to use it, particularly for parental conflict, than used to be the case and I think that is healthy. But it is probably mostly professional-driven, by educators, doctors and nurses, rather than the public at large. I think we still have some substantial education of the public at large. We are really afraid to do that, because the waiting list is already so horrendous we could not accommodate them if we went out and told them there were more services available, anyway. So sometimes we do not tell.

The Vice-Chair: Thank you very much for your presentation.

LAMBTON COUNTY ROMAN CATHOLIC SEPARATE SCHOOL BOARD

LAMBTON COUNTY BOARD OF EDUCATION

The Vice-Chair: We move on now to our next set of presenters. I want to make note of the fact that the Lambton County Roman Catholic Separate School Board, represented by Bert VandenHeuvel, and the Lambton County Board of Education, represented by Peter Cassel, are going to make a joint presentation. It is interesting to see that there is a degree of co-operation among the boards. You will be making your presentation for the combined period of one hour. Whatever way you would like to split that up in terms of your presentation and then questions, I leave entirely up to you. Thank you for joining us and the floor is open to you.

Mr VandenHeuvel: I will ask Peter Cassel to start the presentation, I will kick in when it is my turn and then we will go back to him.

Mr Cassel: If the committee members have in front of them this non-partisan yellow document, this is what we will be using as our reference point. We will be going through it, not reading it word for word; I plan in my part of the presentation to paraphrase some of the sections in it to supplement and add to. Committee members may want to make note of that as we go through for questions later on.

It is indeed a pleasure and an honour to be here today to make this presentation to the standing committee on social development. As we sat in the audience listening to the previous three speakers, we could not help but be impressed. Odd, their perception of school boards. We hope to balance that perception for you today and to share with you perhaps a different point of view, a different

orientation, and I think in total provide for your committee a rather balanced view as to what the needs of these children might be.

We are unique in that we are here today showing co-operation between two school boards in a community, Lambton county, including the city of Sarnia. Not only are we here as two officials from those boards, we are here representing 21 boards of education across the region of southwestern Ontario. Those who know the region will know the city of London, the city of Windsor, boards like Oxford, Kent, Middlesex, Huron and Perth, a variety of boards making up a variety of different structures administratively. We are here as representatives of those 21 boards, working on a county of Ontario that could be considered representative of a rural-urban area, so I want to stress we are somewhat typical.

The proposal we share with this committee calls for improved co-ordination in the delivery of health services to children and perhaps offers a new means for parents to better access the services—and we stress this—that already appear to exist in this province. Before the specific details of the proposal are presented, it is important that the committee appreciates a brief history of the circumstances that have precipitated the current dilemma facing boards of education in dealing with children who require mental health services.

1550

What I would like to do is just go back over a brief history, a brief chronology, for committee members in particular to see what the orientation is of boards, why we have reached this decision to present today.

I was part of the structure that on 12 December 1980 helped behind the scenes to introduce a bill known as Bill 82. Bill 82 is now law. The government of the day proclaimed the bill as a significant step forward and no one, I think, would dispute that.

During a speech to directors of education from across Ontario shortly after the bill was passed, 30 January 1981, the then Minister of Education, the Honourable Bette Stephenson, declared that "the bill ensures that every child of school age must be enrolled in school upon presentation by the parent or guardian."

I was part of the Ministry of Education task force working behind the scenes at the time. It was my job, on loan from the Lambton board, to assist boards in southwestern Ontario with the implementation of that bill. It was an awesome piece of work. In order to prepare the bill, boards of education had until 1 September 1985 to plan and phase in special education programs and services that were required to implement that legislation.

This is a key point, and I want to stress this point, that the Ministry of Education in turn expected to have in place "mechanisms for closer collaboration with other ministries" to provide the additional support services some school-aged children would require. Dr Stephenson, when she spoke to those directors of education, made several points that evening, including that mechanisms for closer co-operation would follow.

In an attempt to gain this closer co-operation, this interministerial agreement, which became known in our

circles as memo 81, was issued on 19 July 1984. The agreement was signed by the three ministries, Education, Health, Community and Social Services, and was at that time the Ontario government's commitment to see that all pupils with special needs received support services they required to benefit from, I stress, an educational program—not a mental health program, an educational program.

When it appeared, the agreement centred on health support services in school settings and failed to mention the provision of services for children who may require services to deal with social, behavioural, emotional or psychiatric problems.

Prior to and since 1984 in particular, the ministry with the lead responsibility, and you heard it in the three presentations today, is definitely that Ministry of Community and Social Services whose collaborative role with the other two ministries, Health and Education, continues not to be defined by agreement or by law. And for that, ladies and gentlemen, that is an issue for us today.

If I could digress just for a moment on the home care aspect, and this is the Ministry of Health, for an administrator like myself or Bert to be able to get on a telephone and call our counterpart in home care and say, "We have a child who requires physiotherapy in our schools. Could you deliver the service?" and not to get a beat-around-the-bush or some kind of vague answer but a direct statement that they can and will provide is indeed a simple and co-operative working relationship. It can happen, and it can happen with a simple change of policy in this province, that we can in fact have a better, easier working relationship if the political and collective will is there. It has worked since 1985 with the Ministry of Health and the Ministry of Education, ie, boards of education.

Since 1 September 1985 boards have assumed that the responsibility for programming for all behaviourally disordered children, regardless of the degree of severity, is entirely their own. If a pupil is admitted to one of the 85 mental health treatment centres in this province to receive assistance, it is more often due to good fortune rather than collaboration on the part of the board of education. The linkages between mental health services and education are left to chance in most communities.

Under the Education Act and regulations, boards of education may purchase services from other boards. In other words, the Lambton public board can purchase services from the Lambton separate board and vice versa, but under current legislation we may not purchase services from mental health centres. That is a key point. Therefore, many pupils who require treatment services are denied access by boards of education who do not see such services as their mandate and from treatment centres that operate according to independent admission criteria which may or may not define the need for treatment from a school perspective. I stress that to you too. We do not always see the world the same as mental health treatment centres, and that possibly comes as no surprise.

During November 1989, the Ontario Association of Children's Mental Health Centres—and you have heard a bit of this this afternoon—began an active campaign to

increase public awareness concerning what it claimed was the rapidly deteriorating quality of treatment services to children. The association claimed that at the time there were an estimated 10,000 children on waiting lists for treatment. Their message called for what they called "universal access," a concept that, if translated into law would see mental health services equated to physical health care services.

By 20 March, the issue of the waiting list for treatment services was being raised in this House and, on 12 April 1990, Andy Brandt moved the following resolution:

"...recognizing the increased incidence of behavioural problems and violence in schools, and recognizing that children in Ontario currently do not have a right to mental health treatment, and recognizing that there are 10,000 children presently waiting for treatment in children's mental health centres, and recognizing that there is a lack of legislation in Ontario which specifically governs mental health services for children, the present government should make the provision of children's mental health services a government priority and take immediate action to ensure that all children in Ontario are provided the mental health services which they require and deserve."

Perhaps, Mr Chairman, that is why you are meeting today.

The resolution passed the House on vote of 46 to 5 and reflected the concern of legislators from all three political parties.

Bert and I belong to a group called the Western Ontario Regional Special Education Council which unanimously passed a similar resolution on 11 May 1990:

"Whereas there is an increased number of behavioural problems in schools, whereas the Ministry of Community and Social Services does not have a treatment role that supports such pupils in schools"—and I would underline "in schools"—"similar to the health support services of the Ministry of Health), and whereas the Western Ontario Regional Special Education Council supports a treatment role for the Ministry of Community and Social Services in schools, be it resolved that: The council requests that the Ministry of Education explore with the Ministry of Community and Social Services the implementation of treatment services in schools by 1 September 1991."

I stress that this resolution had the support of 21 boards of education, that is, the administrators of those 21 boards who deal with special education problems and concerns every day.

As mentioned in our opening remarks, the council serves as a forum for school board administrators with supervisory responsibility for special education to meet with officers from the Ministry of Education at least three times a year. We met in London in May 1990 and the officials from the 21 boards supported the resolution and requested a meeting with senior Ministry of Education staff to seek their reaction. We call this in the vernacular "taking it up the pipe." In other words, we wanted to see if our view of 21 boards in Ontario would be supported here in Toronto and would find support across this province.

On 21 November 1990, the council had the opportunity to meet not only with senior staff from the Ministry of

education, but a senior staff person from the Ministry of Community and Social Services was able to join this meeting. School board administrators were surprised to hear the level of support expressed for the resolution by senior staff from both ministries—I would stress “both ministries”—and were impressed with the level of activity and projects that were taking place in other regions across Ontario. It was acknowledged at that time that only one out of six pupils who require services is actually receiving some form of treatment.

Issues and problems related to human resources, and you have heard many of those here this afternoon already, time and finances were reviewed for the benefit of the council. It should be stressed, however, that a great deal of provincial support and enthusiasm was expressed for the resolution, realizing that there are many real obstacles to successful implementation. You have heard many of those obstacles again repeated for you.

1600

One of the key goals the Minister of Education discussed at the 21 November meeting was a desire to move towards an integration of services—now this is a buzz term; you are going to hear this quite often in presentations, “integration of services”—in an attempt to meet the needs of these pupils. Increasingly, the school is seen as a focal point in the life of a child and the logical place where resources should be located. It makes sense. Health services, health clinics and psychiatric services would be available at the school the pupil attends if the vision of integrated services was to become a reality.

A major benefit of the integrated model, in which teachers work more closely with other professionals, would be that both parties would profit through the professional development. Another benefit, and perhaps the greatest benefit, would be the ability of parents to better access the services in a collaborative mode with the school, thereby keeping their children in their natural homes, their natural schools and their natural communities.

In a news release dated 18 December 1990, the Ministry of Community and Social Services announced the publication of a report entitled *Children First*. The report was produced by the Advisory Committee on Children's Services and made a total of 63 recommendations. These recommendations are designed to ensure the entitlement of children to be “raised in conditions that contribute to healthy growth and development.”

Again, this report calls for the integrated framework that ensures that the entitlements of children are met through a holistic system of “supports and services.” The authors are realistic when they recognize that voluntary collaborative measures among different agencies, including perhaps boards of education, will fail because of “protected turfs, conflicting values and confused accountability.”

In order to bring about the sweeping changes the committee feels are necessary, *Children First* calls for a reorganization of the provincial government to integrate all children's services under a single authority. While this recommendation may be extreme and far-reaching, the intent is clear. The present system is not working well and

that fact is clearly recognized by individuals within the Ministry of Community and Social Services.

If I as an individual may just digress for a moment, this bringing together—and I heard it in the three presentations previously—of some sort of single authority, single children's services, I would view as perhaps a long-term goal, not a realistic immediate possibility. There is just frankly too much turf on the road. What we will present here this afternoon may be an intermediate step along a lot of steps to get to perhaps an end goal.

For a variety of reasons, I am going to pass the next part of the presentation to Bert.

Mr VandenHeuvel: Recognizing that there are some people who have had familiarity with school boards, this may be second nature to you. For others this may be somewhat revealing, if not astonishing.

In any case, what I want to address very briefly is what we in school boards try to do in terms of philosophy when we have to deal with children who need some kind of intervention. Our target is to give the most enabling intervention that we can possibly do. Also, one of our other philosophies is to keep the children in the regular classroom as much as possible.

I will just take a very brief moment to go through what you see on page 7, the diagram which is called the cascade model of delivering special education. What it essentially describes is that what we want to do is keep the children as close to the classroom as possible, and wherever there is intervention, to go to the most appropriate level that is required to help that child.

Now, if you will notice, the first two levels are mostly in the classroom. Then the third and fourth levels are taking the child away from the classroom but still within the school setting, with a regular classroom, with part-time special education in level III, and moving up the ladder, special education where the removal is more than 50% of the time from the regular classroom and will be in a special education classroom. If you noticed, when you move up to level VI, we are basically saying the level of treatment this child needs is beyond what we can do in a school setting and the child should receive treatment prior to getting education. That should take place in a residential school treatment facility or a special provincial school.

The intent is to keep as close to the classroom as possible but to provide the level of service that the child needs and make the intervention as short-term as possible and return to the regular classroom as soon as possible.

What we are basically dealing with is, what can we do within a school setting? I will try to address that on page 8. If I am going too rapidly, I am sure that I will get some questions, but I recognize that our presentation time is limited so that you will have the questions. The model itself is not the thrust of this. I felt you needed the background information.

At school level, we do have the mandate and we are required to provide education to all children. That has already been mentioned and certainly it is nothing new to you. The difficulty is that not all school boards intervene with the same vigour and the same enthusiasm. That may be for a variety of reasons, whether from a philosophical

basis or because of the financial restrictions that certain boards may encounter. That is not restricted to southern Ontario. I notice my colleague, a gentleman from northern Ontario, is not here, but the issues are provincially, not northern and southern Ontario, different. The problem is when you have lack of money, it is all over the place.

What I am trying to say here within this section is that there are problems with commitment on the part of school boards, and that is because we have some options. Currently, the school boards use a variety of interventions, and they can be looked at as a continuum. This could be directly in the classroom, where the teacher may be receiving a teacher assistant to work with a child, or a child care worker. There may be a social worker or someone who works with a classroom teacher, giving some ideas to the classroom. There may be a behavioural class which may remove the child from the actual classroom within his community. There may be linkages between outside agencies and the school board. In any case, the focus is still on the educational needs of the child when we are talking about the mild and moderate cases.

What is coming to our attention more and more, whether it is someone at the public board or, in our case, we are beginning to find that more and more children are coming to the attention because of the fact that they are not getting the appropriate intervention, and they are coming at a younger age. In my previous life, so to speak, I was a principal of a secondary school and we found that we could intervene with the students in grade 9. Now for the last five years I have been superintendent of special education and education, and we are beginning to find that the problems are occurring at a much younger age. In fact, we are now dealing with children as early as grade 1 and grade 2, and these are problems that are out of hand. I think those are the kinds of issues that we really have to be concerned with.

What I want to address in the next section is the severe cases, the ones that we really feel we need some support with, and those are the ones we probably try to address in terms of being at the upper level of that scale that I explained to you on page 7.

The severe cases show all or most of the following behaviours. They have very aggressive tendencies. They are violent in both the classroom and the playground. They injure themselves as well as others. They certainly lack co-operation. They do not adhere to any rules. They are very frequently involved in stealing, frequently involved in violent play, whether that is within a classroom or outside, as I mentioned in the playground. They will not accept any responsibility for what they have done. They just believe that it is not their problem, it is somebody else's.

Defiance—they do not know how to resolve problems. The previous presenter mentioned that it is quite often the case that they do not know how to resolve problems, and obviously when they do not know how, then they use what they are seeing on television, which is often very ineffective. The list goes on, and I do not think I need to dwell on each of them, just to recognize that these are very severe when we are dealing with them in a school setting and also when the child is still at home in a family.

1610

The nature of the behaviour and emotional problem is so disruptive to the child's normal development that learning is negligible. They are currently in schools, but I assure you that they are not learning much. If they are learning, it is just by chance. In fact, the school board's primary responsibility related to assisting students with skill and knowledge acquisition, which is one of the main mandates of schools, is superseded by treatment of the child.

In other words, we cannot deliver education. What this child needs first and foremost is treatment and that is not the capacity of a school. We do not have the education, the training, and therefore we do not do a good job at it. Most school boards do not have access to funds to provide for that level of service.

Access to outside treatment agencies is often non-existent. Maybe those of the ones—we have called it a crack but I can assure you that it is more than a crack; it is a huge gap. The access is non-existent or often much delayed. School staffs and administrators can at best provide a caretaking approach. Essentially what is happening is that we are keeping a body in the school, keeping it warm, keeping it off the street, but we are not carrying out our mandate which is to provide education. The impact on the individual school is that we are just controlling it. On the child, it is even worse. It often adds to additional frustration for the child as lower self-esteem because of all the things that are going on in his or her life in the classroom and in the schoolyard, and essentially what happens is that he becomes isolated from his classmates.

You wonder, are we talking about huge numbers in every school? I can assure you that what we are talking about here—we may be somewhat conservative because we are trying to focus on the primary and junior divisions of the schools—when we are talking about the mild and moderate, I can assure you that there is probably one in every school. When we are talking about the very severe, the ones we are trying to deal with at this point, we are not so sure that we are talking about one in every school. In fact, we estimate that within our two school systems we approximate one for every four schools, so we are talking about roughly, in the system I function in of 20 schools, we probably have about five or six youngsters who really need the label of "severe" and need the treatment we are talking about.

Again, what we are mentioning here is that it is occurring at a much younger age and we feel that there are a couple of solutions to it that this committee should focus on: early intervention and appropriate treatment and prevention. Again, we believe that we have a task to do in education on both those issues.

Again, we do not want to claim that we have invented something new here. Children come as whole entities. They do not come neatly divided for Education, you know, where we deal with the intellectual, and in the Health ministry we only deal with the physical, and the social and emotional would be given to Community and Social Services and the cultural to the recreational. Kids do not come neatly packaged and say, "Well, you've got a problem here; go get a solution." They come as whole entities.

The problem then that we have to address is, how do we solve it when these children come to us with problems? This requires co-operation on the part of government ministries. We have to co-operate and collaborate and take responsibility for providing the services that are required. This co-operation then should be based on a partnership of equals, not where one ministry decides that it will not accept responsibility because of a lack of staff, a lack of funding or different priorities or an unclear mandate. I believe that this is where the current problem is, that we have these issues in existence and as a consequence we are not providing the services that are needed.

Peter mentioned a little bit earlier policy program memorandum 81 which outlines the responsibilities that should be assumed by the Ministry of Education, the Ministry of Health and the Ministry of Community and Social Services. It is our view that too much flexibility currently exists for the lead ministry, Community and Social Services, to delay or to deny services altogether. We do not have that privilege. When the children come to our door, no matter what their problems are, we have to deal with them. We cannot say, "Well, we'll make a waiting list and when we get to you we'll get to you."

We believe that is part of the problem. The impact on the decision-making ministry, Community and Social Services, is relatively minor when it says, "You're on a waiting list." Neither the child nor the parent has much political clout to get something changed as individuals, so there is not much of an impact on the ministry by the decision that creates havoc within the child, the family and the school.

To state the obvious, the child and the family cannot remove themselves from the problem. They live with it and all of the consequences. Even at the school level we begin to distance ourselves to some extent. The principal may at some stage say, "You are suspended from school because of the consequences that you are delivering to other children." If it gets worse, then the board may say, "We are going to provide education within the home."

That still does not solve the problem for the child and that particular family, so we feel that part of the solution has to be to remove that optionality from the ministry that is charged with providing care and treatment, and again the emphasis has to be on treatment. As long as there is no treatment, we cannot do the job of educating.

We agree with the reports that have been brought to our attention this afternoon, and I want to focus just very briefly on what Peter mentioned just before he turned it over to me. Our concern is that before all these recommendations that you are going to come up with as a committee can be fully implemented, hundreds, if not thousands, will continue to fall in that crack and be denied access to essential treatment. We also concur with the report Children first that the school is the key to the solution. We already serve as a focal point for children's lives probably from age four and onward, in most situations, to the age of 20, so that whether we recognize it or not the school is a focal point.

Parents feel relatively comfortable—I am not saying all parents and that they are always at ease, but relatively

speaking when they come to a school they feel comfortable in dealing with the staff and the personnel who are there. There is no stigma attached and that is one of the concerns the previous presenter mentioned, that there is usually still the stigma when you seek mental health care. If that is provided and looked after at the school level, perhaps that would be eliminated or at least reduced.

In any case, what happens is that if there is treatment provided by another agency the school has to be part and partners with that treatment. It is only when that partnership takes place, when we take our share in assisting that child, that there will be long-lasting effects on the child or the adolescent.

I also want to caution the committee members that school boards cannot assume this additional responsibility without some reallocation by the Treasury department. Now, earlier one of you asked the question of the minister, has she made some overtures to the Treasury department? We certainly encourage that if this is going to take place, that some additional responsibility be laid on the Ministry of Education, that through school boards some funding be provided so we can provide the personnel and the facilities and the administration that is required to do the job.

The last paragraph indicates it would be unfair for us not to offer at this time to the committee what is felt to be a means of dealing with the problem on a scale that addresses the issues of funding, availability, accessibility and collaboration in a manner that is responsible, and I believe that is the mandate of this committee. So Peter will now try to present you with one working model and there may be others.

Mr Cassel: When we began our investigation, it was again northern Ontario that seemed to be leading the way. In a particular board in northern Ontario, the Central Algoma Board of Education is part of a group known as the Integrated Services for Northern Ontario, ISNO.

The group was formed by the three ministries, Education, Health, and Community and Social Services, about nine years ago and during most of this time it has remained dormant. It has not been an active group. In reality, ISNO has only been in operation for approximately one year. It was built on good intent. However, the mental health centres throughout northern Ontario have received extra funding to provide extra staff to assist this particular program. Details of the amount of funding unfortunately are not available to us, but are said to be modest increases to existing program departments. I would stress that is what we are saying today. We do not think it is necessary to build an entire restructuring of the system. What we have discovered in northern Ontario in the model we are about to present is not a great incremental cost structure.

When a principal of a school within the jurisdiction of that board makes a request to the local centre for services, a protocol has been established that it clearly define what action may be expected at the school level to deal with the referral. In other words, they have agreed on a game plan well in advance. It is articulated, written down and the script is followed. The consent of the parent is sought before the referral to the centre has been made. Criteria have been established to determine whether or not the

referral is urgent and thus a priority for the assignment of staff.

1620

If it is determined to be a priority, the services are provided in most cases—here is the magic we are looking for—in the school. The board of education, in this case the Central Algoma Board of Education, does not provide funding for any aspect of the services provided by the centres. The schools in turn have been very conservative, and I would stress that with a small c, in their referrals and have not done so unless there were what the director of education terms a real problem.

Most of my information on these pages, on pages 12 and 13, comes directly from Mel Baird who is the director of education. Some of the committee members may know him.

Their incident rate would be similar to what Bert mentioned earlier, about one of these children for every four or five schools. In the board I am responsible for, we have 18,000 pupils. At any given time, there are about six to 10 of these pupils in our system who are causing the system a lot of anxiety, about six to 10 out of a total population of 18,000.

The ISNO model is not perfect and both the educators and treatment personnel have gone through periods of stress and adjustment. This is a normal process and is to be expected when individuals with different mandates must work together to establish common goals. The same stresses were felt when board of education personnel began to see health care professionals in schools around mid-1985. The practice of medicine has been left to qualified personnel in the schools and teachers have been left to do what they are trained to do; that is, educate. The pretence of providing treatment services to pupils by placing them in special education programs is a time bomb whose tick is becoming increasingly amplified.

Bert and I are here precisely for this reason. We are increasingly feeling more and more uncomfortable with boards of education providing services that are clearly treatment as opposed to education. It is almost unfair. Clear and decisive government action is required to deliver on the commitment that Dr Stephenson made, at the first part of our paper.

In conclusion, boards of education, at least boards of education in southwestern Ontario, are seeking access to the range of psychiatric treatment professionals who are not currently available to schools. As you have heard, the proposal is rather conservative and attempts to focus on the truly severe cases, the cases in greatest need.

Boards of education were promised collaborative services as part of their new mandate to educate all pupils, exceptionalities notwithstanding. The resolution that was adopted by the Western Ontario Regional Special Education Council in May 1990 was simply a restatement of the need for collaborative treatment services similar to those health services first identified by Dr Stephenson in 1981.

It is time that the commitment was honoured and boards of education and the parents they serve have a mechanism to access the range of school-based treatment services, including from time to time institutional settings

if need be, that presently are under the authority of the Ministry of Community and Social Services.

This is quite a machine-gun approach this afternoon. I would welcome questions.

The Vice-Chair: You have given us a great deal to discuss.

Mr White: I want to express my appreciation for your report. It is very thorough.

The issues you deal with, in terms of the problems that some children may present within a school board, where the mandate, the direction and the emphasis of course is on education and not on treatment, has been a perennial problem I understand for many, many years.

On page 11 of the report, you mentioned the recommendations of a provincial children's authority. You seem to concur with it and yet you are saying there needs to be something done beforehand. Could you comment further on the idea of a provincial children's authority.

Mr Cassel: I would be pleased to. As an intermediate step, and perhaps this provincial children's authority could remain a goal for the province, I would welcome the opportunity to be able to pick up a telephone and call my counterpart at the Ministry of Community and Social Services office and say, "We have a need," and to know that Comsoc officer also has a similar responsibility. He or she would have a mandate to provide services.

That does not mean our judgement, our assessment, has to be taken at face value, but at least there is an opportunity to begin the dialogue right there at that point. This is the coming together of Education with Comsoc. We do not mean that it would come under. It does not mean that we are under. It means we are co-partners, that we are, as we said in the paper, equals. Both have a clear and distinct mandate. When they said that they envisioned a provincial children's authority, I would see at this point in time of the evolution of services in this province that it would be absolutely disastrous to move forward with this rapidly.

Mr White: As supplementary, what would you see as being an intermediary step?

Mr Cassel: An agreement or law which brings Comsoc into this fray clearly and decisively as a partner. Right now it has no legislated role, as we can perceive it.

Mrs McLeod: I also appreciated your report very much. My struggle with the issue is the distinct mandate, because as you have said the child is a holistic individual and it is hard to separate the child's needs so clearly between the mandates in the different ministries.

With that in mind, let me just press you a little bit more on the intermediate step model you have proposed, because it seems to deal more specifically with the more severe behavioural problems and the access to service for children who need that kind of service.

What about the child with a milder, moderate behavioural problem in this school? Is that not a frustration for school personnel to deal with, given the fact that your central mandate is to deal with the learning needs, the special education needs? Yet that child with the milder, moderate behaviour problem, if it is specifically related to the learning problem, in all likelihood needs some

involvement and intervention with the family, and the school has difficulty doing that and lacks the trained personnel to do it.

Mr VandenHeuvel: I will take a stab at that and perhaps Peter can add to what I have to say. Yes, it does add to frustrations in the classroom. I can certainly vouch for the fact because we started a committee of five schools which really brought to our attention that they had difficulties with these. You hear the teachers speak and you hear the principals speak on these issues, and yet they feel that they can manage this with support, so we are not saying to the schools to sink or swim. They need support and we have to do some in-service training. Depending on what range they are at, if they are towards the upper end, with needs towards the severe of the moderate level, then we probably need social service work with direct intervention if a social service worker, which is a professional in a classroom with specific strategies.

On the other hand, if we are talking of the lower end of the scale, the mild—someone earlier in the presentation estimated that possibly we could do a better job of doing some work on the prevention, that if we did it in the earlier stages in education and get some social skills programs, possibly we would even prevent the mild arriving at this particular level.

It is frustrating. They are asking for help. We feel we can do it at the school level with the current staff available, with some supports from outside. When we get to the severe, we cannot handle it because those children need treatment before we can educate them.

Peter, do you have anything to add to that?

Mr Cassel: No, that is fine.

Mrs McLeod: If I may, I think you are very brave. In long-time association with school boards, I was quite honestly impressed with the focus being so much on the needs of children that schools were willing to take on more and more responsibilities simply because the children were in need. I know that the support was not always there and this is another step. I hear you saying you are concerned that although you think this is the way to go, will the support be adequate? But I have a sense that even with those mild and moderate cases, if we are talking about early intervention, some additional resources to deal with the family aspect of the intervention that is needed, the school needs that support.

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Mr VandenHeuvel: Some of it relies on the goodwill of teachers. I recognize that. I know that Peter had similar experience in some of his schools, that there are teachers who are there providing breakfast programs so that later on in the day the behaviour problems will not occur. A lot of it is because of the enthusiasm of teachers and the willingness to go the extra mile. I am sure if we said, "This is an expectation," there would be a whole different issue, but they do provide it and it is working so far. But we do need help for the ones who get towards moderate and towards severe.

Mr Beer: The figures that you used around the roughly one child in four schools who would, in your view, have

a need for major intervention and help—I wanted to be clear on that because I think sometimes you wrestle with, in terms of all the kids, when they have need of help, what are the relative degrees and where we should be really focusing. You mentioned that was from your own area, Lambton. Would you say that was reflective of the south-western Ontario school boards that you are speaking for today as well, and do you know if that could be applied more broadly, or would you expect that perhaps Metropolitan Toronto or Hamilton or Ottawa, some of the larger urban areas, would have a greater need in terms of those most at risk?

Mr Cassel: I will try that one, Mr Chairman. I think what you can hypothesize, and I frankly have no evidence to support this today but I think it is good common sense, is that the larger, more densely populated urban areas are going to have a higher incidence of the type of children we are defining here. The smaller, more rural boards of education will have, just by the nature of those boards, far less incidence of the type of children we are describing as severe. My experience borne out visiting and working with boards of education across southwestern Ontario would reinforce that. It would be difficult for me to give you an incidence level in Toronto.

Mr Beer: But certainly your sense is that in London or Windsor, for example, it is likely that that could be one per school as opposed to one in four.

Mr Cassel: Possibly.

Mr Beer: May I just have a brief follow-up to that? The other question that emerges, I think, as we look at structures as to how to then really come to grips with this, and I would like your thoughts on this, is, should more funds and more personnel be allocated to the school board so that those people in effect are in your employ, the additional staff that you need to deal with many of these problems? Or is it more that you want to have the money and you would be purchasing that, be it from children's mental health centres, from a local hospital or wherever? It seems to me that becomes fairly important in terms of how we put together the sort of children's authority, if you like, if we were to follow the Maloney model. I just wonder, where would you see that working out?

Mr Cassel: Perhaps neither option, with respect. There is a third alternative to consider. That is to perhaps better fund the mental health side of things so that those people, as we discovered in central Algoma, can in fact provide those services in co-operation with the board of education. We are determined—I think Bert and I would say this and so would the other 21 boards—to keep our identity rather clear.

We are a board of education, not a board of treatment, not a board of care, not a board of anything else but education. That is our primary mandate. As soon as you start clouding this by boards of education hiring psychiatrists, social workers, child care workers, and the list goes on, you begin to blur that distinction, you begin to blur the mandate. So I guess, in summary, what we are trying to stress here is, we want to be able to work with that sister ministry; not take from it, not take its staff or any

programs, but I guess frankly to have it clearly as a partner in this treatment-education delivery.

I will give you an example that just crystallizes, perhaps, for committee members one of the reasons I am here today. I have a 13-year-old student within our system. That student right now has not one but two teacher assistants assigned to her every minute of every teaching day. She can become violent with no prior warning, aggressive to not only herself but any other children in close proximity, or adults or teachers or authority figures. We are left, frankly, as a board of education, taking the dollars-and-cents resources of those two teacher assistants and applying them to that individual child. Are we providing treatment or education? I would say on the scale of things, we sure are not providing much education day by day. It is containment, it is control, it is therapy of some sort. It is well outside our mandate. Ten, 15, 20 years from now the parent may come back to us and say: "My child worsened because of what you tried to provide. You caused a deterioration. You did not provide the treatment services my child required."

I paint that scenario briefly to illustrate to you we are providing special education programs and services, not treatment services. We do not advertise them as such. But increasingly our mandate is becoming more and more blurred as we get more and more children who have unique needs. Ten, 15 years ago that child would be in an institution; no doubt about it. That child now is back demanding education in a community school.

That is the balance. That is what we are trying to seek in this particular report, and I think one child is typical of the type of children we are discussing.

Mr Hope: I noticed your pyramid there and I started to wonder about the pyramid in itself. Are we not labelling more children? I guess my question would be, who would do the categorizing of that individual? What kind of level would that individual be at? I guess I question where that would be.

Is it not true that between the educator and the services provided in a lot of the communities—and I am talking specifically in the Chatham-Kent area, where I come from. As we are trying to work more closely with the boards of education to try to get access to the services, the services are not there. We do not have in rural Ontario the special qualified individuals to do proper analysis, and they only come in once or twice every week, or something like that.

I guess where I am starting to be a little hesitant is about your labelling of children in the school system as to behavioural pattern, as I see the TV—and my own son is one of the victims of World Wrestling Federation wrestling who likes to be a part of it. I guess I question the labelling of a child and the categorizing of that child. Does that not create more of a problem because the children the child may go to school with are now putting on more emotional pressures? I personally would like to see the parents more involved with the child, with the process of trying to correct it, because there is no sense in the educators fixing the problem and the social worker fixing the problem and then putting the child back into the home, and the problem is still there when he gets home.

I think there has to be a joint effort by the parent, the educator and everybody who plays in that field to be a part of it. As you say, we are trying to close the cracks up. We have got to close the cracks up right there. Everybody has got to work together.

Mr Cassel: May I just comment? I think it is fair to say boards of education can deal with the WWF. This is the child who does not fit this category, does not fit the definition we are presenting today of severe. This is the child whose behaviour is extreme. The behaviour is obvious to most people who deal with this child not only in school but in the community, anywhere the child interacts that this is a child obviously in need of additional services treatment services in this case.

I do not want to make light of the cascade and so on. It is simply a conceptual model that we deal with to discuss and kind of conceptualize children. Children do not appear in cascades or packages, they appear as entities.

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Mrs Witmer: First of all, I would like to congratulate you on what I feel is an excellent report. I think you have certainly presented the case of school boards across this province extremely well. You have allowed the committed the opportunity to see how they do function in relationship to the students with special needs. I also appreciate the fact that the two boards did collaborate.

You have mentioned the fact that you are now starting to provide treatment rather than education. Certainly, coming from a board of education myself in the last few years this is something that I heard more and more frequently from teachers and administrators. They express to me their frustration that they were providing treatment, as opposed to education, and there was nowhere that they could access this treatment. Really, I know many educators in this province are at their wits' end. I know some boards have created behavioural classes to deal with these students, and as you have indicated, you provide treatment. How many behavioural classes have you created, or how are you coping with all of these students with severe emotional problems?

Mr VandenHeuvel: In our case currently we have one for the intermediate level. That would be grades 7 and 8 essentially. Because of the needs we have within our community, we are looking at whether we need something for the primary and junior division, because some of those youngsters who really ought to be receiving treatment are still within our schools. We cannot get them treatment, and when the treatment is there, it is often too short to make a major change, so they come back in our school systems. So we are looking at having one for the primary and junior division, which is grade 1 to roughly grade 5 or 6. We are looking at it very seriously now to see what we can do and we want to do a little bit more than holding them and, to do what Peter says, to more or less put them in a holding tank. We want to provide some kind of treatment, even though we are not really treatment personnel. But we want to do something. I guess we feel helpless just to let them sit in a regular classroom and veg out and where we have

to have someone supervise them and control them on a one-to-one basis.

In our system we currently have one. We are looking at the possibility of doing another and then there is still the area of the secondary, which can also have youngsters. If we do not do something with this group, the secondary area will become even more severe. So there is some demand from the secondary personnel as well.

Mr Cassel: I would just offer this opposite point of view. We tried a behavioural class. It lasted for one year. It was just like taking six pieces of sandpaper and bringing them together. They just grate and spark off each other. It took us one year to realize that was not the right approach for our system. We tried also to have a co-operative venture with one of our mental health treatment services in our county. That went fairly well, where we had treatment and education going hand in hand. It was a section 27 class, of which some of the jargon here—it is simply an access for our services. But that had to be discontinued because the Ministry of Community and Social Services folks were not receiving adequate funding and could no longer continue to provide that service.

Our approach is simply now to try to divide and conquer, to keep the children away from each other, possibly with teacher assistance or in smaller special education classrooms or whatever, but it is not to bring them together. So each board will have different approaches in trying to cope. The point is, cope alone.

Mr Martin: I would say first of all I am impressed with the two school boards coming together and presenting this. However, your presentation does create some real concern for me, I have to say. It has caused me some confusion in that, on one end, we hear that there are waiting lists of people in our communities who are in desperate need of service of a mental health nature, and yet I hear you saying—tell me if I am wrong—that there are not really that many, that there is one in every so many schools who would be considered severe. Maybe I am just not understanding the levels of severity, but I just need to be clarified on that. The problem, as far as you are concerned, is huge out there. There are all kinds of kids who need service and we need to develop a system that speaks to its working properly to the benefit of the children. I hear you presenting a very simple answer, which is to have Comsoc sign an agreement to carry its end of the Bill 82 agreement of something that was passed, and yet I do not know whether we would be here today if there was a answer that is simple just readily available.

I guess I have to say that it creates a need to hear from some folks who are perhaps the parents of children so that they might tell us a story that they have lived through with their children. I know, having been a trustee with the school board and also working with social services and addiction research people, that school boards in my experience have denied very much the presence of drugs in their schools when confronted about it. That got in the way of any effective programming being put in place. Anyway, just throw that out to you for some comments.

We know that it is there. I would focus on what we have tried to show the committee. It is the truly severe that we have tried to address in our statistics. Again, I also want to state, from my perspective, I was working at the truly severe in the primary and junior division. If we look at the entire school system, that probably would be two out of four instead of one out of four. Now, that would be for my school board.

The Vice-Chair: One final comment, very brief. We have just about run out of time.

Mr Cassel: What we envision, again, to repeat the concept, as clearly as we can: Mental health centres will have their own totem-pole, their own priority ranking. They can admit, they can be demit, they can do the treatment. But when we have a child of the type we have described here today identified in a community, service has to be provided, and that may cause disruption in the totem-pole. "Mild" may be bounced off, I am not sure how many, but that child we have described here today has got to be considered a priority.

The Vice-Chair: I would like to thank you for an interesting perspective that you have brought to our discussions and a very wholesome debate that took place. I am sure it adds a great deal to our bottom line which will be dealt with by our researcher, and a lot to consider there in terms of the new model. So thank you very much.

Mr VandenHeuvel: Thank you for allowing us to make a joint presentation. Two heads are better than one.

KINARK CHILD AND FAMILY SERVICES

The Vice-Chair: Our next presentation is from the Kinark Child and Family Service. Jeanette Lewis is the executive director. Welcome to the committee. The floor is open to you; you have half an hour. I am just looking at the clock to note when we start our time here.

Ms Lewis: I would like to thank you for this opportunity to present to the standing committee on social development and I would bring special greetings to Mr Beer, who is the member for York North, where Kinark operates one of its programs. I understand also that Mrs McLeod was involved with our program in the Thunder Bay area when we were operating a program there.

Kinark is a not-for-profit children's mental health service with programs throughout the province. I have listed in my written presentation where we serve children. We have operations in Simcoe county in the city of Barrie and the city of Midland. In the regional municipality of Durham we run a program in the city of Oshawa. In Northumberland county we have programs in the city of Cobourg and the town of Campbellford. In Haliburton county we have a program in the town of Haliburton. In the regional municipality of York we have a program in Newmarket and in Georgina and in Peterborough county we have a program in Peterborough. As well, we operate in Haliburton county, near the town of Minden, a large outdoor site which provides therapeutic recreation programs for children with special needs from Kinark and also from some 28 other not-for-profit social and health care organizations.

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We are a transfer payment agency, in the nomenclature of the day, and we serve over 1,000 children annually. Our organization gets all of its money from the Ministry of Community and Social Services in this transfer payment mechanism.

I think it is fair, when we talk about children's mental health services in Ontario, to recognize that there is a vast array of services in our province and that our province has shown leadership in providing high-quality professional services. I think this is a credit both to the government and to the service providers, and many jurisdictions are envious of what we have accomplished. So we should not be too distraught with all of the criticisms we have heard today. However, it is a day to bring forward issues, and as we bring these issues forward I would hope that the committee is also mindful of the many successes we have in our province.

I think it is also worth while noting the kinds of children's problems which are served in children's mental health centres. Most of the children we treat at Kinark have very, very serious problems, things like suicide attempts, self-injurious behaviours, sexual and physical assault—and in that category we have both the perpetrators of assaults and the victims—fire setting behaviours, property damage and threatening behaviours towards authority figures.

I am astounded when I read the next statistic, which is that 95% of the children who are admitted to the residential treatment beds in our programs have suffered from some form of abuse, primarily sexual abuse.

To articulate the severity of the problems demonstrated by the children in our centre, I would like to describe 29 cases which were referred to us under the age of 10; these were recently surveyed by two research consultants from Kinark, Eugene Sunday and Ruth Parry. They looked at the problems these children demonstrated at referral—and remember these are children under the age of 10. Over one third of these children were referred because of withdrawn, anxious and fearful behaviour, which often included a preoccupation with thoughts of death or threats of suicide. In all of these cases there had been a parental separation within several months prior to the referral.

Two other major groups were identified: One group was referred for highly impulsive, overactive, disruptive and aggressive behaviour, the aggression often including assaulting another child or adult with some form of weapon; those from the last group were referred because they were victims of intrafamilial sexual abuse. Of these children, the boys demonstrated physical aggression to other children, defiance and negative behaviour. The girls tended to be described as depressed and withdrawn.

I brought these data because I felt the committee would like to have some understanding of the kinds of problems that children's mental health centres deal with. We had some debate earlier today about whether this is psychosocial or medical or whether it is learning disabled or whatever. I think the truth is that we have a very severely disturbed group of children who are often put together

under various labels, but none the less they come to the steps of our children's mental health centres.

I would like to refer next to the Ontario Child Health Study, and I know Dr Offord is going to be appearing tomorrow. In the study it was found that 18% of Ontario's children demonstrate some form of psychiatric disorder yet only a very few of these children can be treated. We have heard from the Ontario Association of Children's Mental Health Centres, of which Kinark is a member, that we have some 10,000 children waiting for treatment yet our system is primarily focused on a case-by-case method of service delivery.

I think we have to look at incentives to develop other methods of service delivery. We are just not going to be able to do it all on a one-by-one-by-one basis. We have to start looking at populations and more systemic kinds of interventions. We need some kind of incentives so we are able to develop these kinds of initiatives. Certainly the kinds of proposals which were submitted to the Better Beginnings, Better Futures project would be a good place to start in terms of creative responses.

We also articulate a position here that all communities in Ontario should have access to a full spectrum of children's mental health services, which would include primary prevention, co-ordinated treatment service delivery and advocacy to represent the best interests of the children and the families who are requiring service.

As we have heard today, children's mental health services in Ontario are primarily delivered through a voluntary system, and our centres are run by voluntary board members who give many hours to try to decide how our services should be organized. The most chronic issue faced by our boards is that of funding shortfalls, and an inordinate amount of time is spent on dollar kinds of issues.

In the last five years, base funding for Kinark has been increased in lesser amounts than the consumer price index. This is no news to anybody, but this is further compounded by wage settlements which we have had to make well beyond the CPI. These have not been unreasonable settlements; these have been settlements which were instituted to try to bring front-line workers in our industry to some reasonable rate of pay. Regardless of those settlements, we are still faced with a situation where front-line workers are paid fairly unattractive salaries. When I came to Kinark just a very short time ago, we were at that time paying our front-line child care workers just a little more than \$22,000 a year.

What we have to do to even maintain this level of service is to continue to cut back on the kinds of services that Kinark was funded to provide. We have had over the last years a gradual erosion of services in our organization, and this was done purposefully by our board of directors because there was a commitment made that we were going to maintain quality even if it meant we had to reduce some of the quantity. The problem is that residential treatment beds get reduced and other kinds of critical services get reduced and then there is a ripple effect through the system.

We have just heard a good description from our colleagues in the board of education, and I am sure the

children's aid societies, when they come to speak to you tomorrow, are going to talk about the kinds of difficulties they are having servicing this same population of children in foster homes and in group homes in Ontario. Those facilities are not funded or organized in a way to deal with the kinds of difficult children we are describing here. We really need to look at a response that is going to target all four sectors.

The funding problem is particularly frustrating in children's mental health centres when there is a perception that direct-operated government facilities with similar mandates enjoy a higher level of funding support, and we have heard other speakers today refer to this. The level of funding is manifested in the most basic way in rates of pay for our front-line workers, and I would like to refer to a study that was done by the executive directors of the Metro centres during the summer of 1990. At that time, we surveyed the salaries of child and youth workers in our system and compared the results to a similar classification in the public service, which is, I believe, the child care worker 1 classification. The average rate was \$24,222 per annum in a transfer payment agency, while a similar person was paid \$35,111 per annum in a government direct-operated facility, so it is little wonder that somebody is going to make a career shift when offered an opportunity in a direct-operated facility. Needless to say, this has caused some fairly severe issues of recruitment and retention of qualified staff in our centres. Staff often come for basic training and then leave us to go to better-paid positions, and the net effect is that we have a very high turnover of staff.

I would also like to comment on the services approach to budgets which has been required in our system during the past years. This is actually a well-conceived plan, but in reality it operates very poorly. Annually, each organization prepares an elaborate service plan document which details what services will be performed by the organization and at what cost. In many organizations these documents are over an inch thick; any of you who have sat on boards of directors are well aware of how complex and how complicated they are. In reality, all of the players know that the real rules are to take the approved base budget, add the percentage increase in the transfer payment allocation and then dovetail the services to fit, so we go through a time-consuming and frustrating exercise which is perpetuated and which really does not change the essential context in which services are delivered.

We have also had, as transfer payment agencies, significant additional costs resulting from government-driven initiatives such as the employer health levy, pay equity, accelerated remittance schedules for source deductions—this is primarily on the part of the federal government—and now the GST. Although we support these government initiatives, we need to have the resources to pay the costs. For Kinark alone, the cost of pay equity will be \$1 million. We began to pay that last year and now in 1991, but we have really had very little support in terms of how these high costs will be met other than the requirement that it be found in our overall base budget.

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In addition, our agency faced additional costs of \$500,000 per annum when we adjusted the staffing pattern to allow two staff on night shifts after a staff member working alone was murdered. Because of this serious incident, we have implemented the standard of two staff working together during the night and have received no additional funding support to ensure the personal safety of staff in a high-risk industry. We recommend that all residential centres in the province receive adequate funding to ensure that staff do not work alone in a treatment house.

I would also like to comment on the annual planning time frame. We have a budget cycle that goes on an annual basis, so the planning time frame tends to be annualized as well. We would like to urge the committee to look at a longer planning time frame which would allow for some true planning and which would be based on services requirements such as child population and social indicators rather than the audit-driven time frame that we are now under. We are certainly not opposed to monitoring and audit requirements—I think that is part of good accountability—but the two must be separated.

The funding constraints have not allowed alternative forms of service delivery to develop during the last five to eight years. In fact, in the children's sector there is virtually no research and development component. I do not think you would find any industry able to operate without R and D. We are trying to respond to the needs of children in the 1990s using treatment and prevention models which were essentially developed in the 1960s and 1970s. Because of the extreme funding constraints, all of the dollars have gone into service and there has been very little money for any kind of research or program development which has offered new models to meet the kinds of changing needs. I rather facetiously ask how many of us would find a 20-year-old car acceptable today, but I will leave that for your reading.

We from Kinark Child and Family Services urge that there be incentives developed for linkages among ministries. We have seen at the interministerial level some significant developments, but we have not seen this played out in the local communities. I think what has happened is that we have seen occasionally what we have called investing-for-children dollars flowed to the local communities and local children's services committees then asked to recommend how these dollars should be divided. As one of our local area program directors said to me, "It's like a bunch of vultures swarming on a piece of prey," because nobody has seen new money for so long. So it really begs any kind of true community needs assessment and it basically becomes one of power and politics.

I have closed the paper with some recommendations, basically that we look at funding inequities among ministries and between direct-operated government facilities and transfer payment organizations, address them and rectify them.

We look at the budget cycle, and I would encourage you to look at a longer time frame to allow us to implement some significant changes to programs.

I think we have to look at economic incentives to encourage interagency and cross-sectoral programs to develop. I think I say in my paper that value statements and philosophies are fine, but sometimes you have to put your money where your mouth is. If that is truly what is believed, then we have to find some ways to help people to live the values.

We also recommend that all residential centres in the province must receive adequate funding to ensure that double staffing and other necessary safety measures are a minimum standard in all treatment facilities. I think it behooves us to make sure there is not another Krista Sepp disaster because of a funding shortfall.

Last, we recommend increased encouragement and support for prevention and promotion initiatives such as the Better Beginnings, Better Futures project, to begin a process of developing creative responses for the children in our province.

Thank you for allowing me to present today.

The Vice-Chair: I will just point out that we have approximately 15 minutes for questions. I have thus far Mr Jackson, Mr Owens and Mr Beer.

Mr Jackson: Thank you, Ms Lewis, for a very pragmatic report, well written and presented. It was very easy to follow and it will be helpful to the committee.

I am interested in the dollars, and you referenced those in a couple of areas. You do that with respect to the costs of pay equity. Not all your centres have implemented at this point in time?

Ms Lewis: Yes. Kinark has negotiated a pay equity plan with both of our unions—we have two unions in our centres—and also with our non-union staff. We paid our first stipend last year, which was at the minimum allowable rate, which is 1% of the amount of the annual payroll, I believe.

Mr Jackson: Yes. You indicated earlier in your presentation, prior to that point, that one of your creative responses to these situations was to reduce not the quality of service but the level, the degree of service, cutting beds, and so on. Do you have that in more specific information with respect to staff that have been let go—or not replaced, I guess, is the more appropriate, non-offensive way of putting it—and/or beds that are no longer filled?

Ms Lewis: All right. I have come to Kinark recently, so I cannot talk to you specifically about the number of staff.

Mr Jackson: Is there someone else in the room who might be invited to join you?

Ms Lewis: I would refer you to the number of beds, though, because I can speak to that. I believe that about eight years ago, Kinark was operating 198 beds throughout the province. We are currently operating 72 beds. Now some of those beds were divested as part of a planned divestiture for other services to take over the services. But our not-so-creative response in terms of the erosion of dollars has been to cut beds, because it has been felt strongly that we are not going to jeopardize the quality of what we offer to the children we serve.

Mr Jackson: But cutting beds means cutting staff, because you are on a bed-staff ratio.

Ms Lewis: Yes, although I think in some respects the standard of staffing at which Kinark is presently serving its children is somewhat more enhanced than it was eight years ago as well.

Mr Jackson: So your staffing ratios have grown?

Ms Lewis: Yes.

Mr Jackson: Very quickly, Mr Chairman, if I may with respect to the reference, I was under the impression that additional dollars did flow to agencies after Krista Sepp's murder, that in fact there was an announcement that additional funding was transferred, and I get a sense that you are not realizing it or that it was absorbed somewhere else. Could you clarify that a little better for me?

Ms Lewis: There were additional dollars announced. They were flowed to young offender facilities. Kinark is not one of those, so we did not get any of it.

Mr Jackson: That was the catch-22.

Ms Lewis: That is right.

Mr Jackson: So they were announcing based on an incident, but they were not the beneficiaries of the—I remember now.

Ms Lewis: That is right. The organization in which the incident occurred got none of the money.

Mr Jackson: Yet you are faced with having to provide the adjustments in the best interests of your staff, and this is an agency cost of \$500,000?

Ms Lewis: Yes it is, because, you see, we did not implement it only in the area where the incident occurred.

Mr Jackson: Yes. It is a legitimate concern in all facilities.

Mr Owens: Further to Mr Jackson's questions around staffing, with a 30% turnover rate in your centre, how are you able to provide the safe levels of qualified staffing during shift periods, or are you faced with having perhaps one qualified staff versus three unqualified—or volunteers or bodies, for the lack of a better word?

Ms Lewis: One of the things that we are faced with doing is paying very high dollars for overtime costs and to provide relief shifts with qualified people. We try not to staff our centres with people who are not qualified. We have an extensive training program within Kinark which people undergo before they work shifts in the residence.

Mr Owens: Just further to the overtime statement, how do you deal with issues of a burnout?

Ms Lewis: I think the burnout issue is reflected in the turnover rate. That would be my uninformed guess. I think people deal with it by walking.

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Mr Owens: In other words, if it is not being dealt with, they go out the door. They vote with their feet.

Ms Lewis: Yes. Unfortunately what happens is that the quality of care suffers because once people feel like they are ready to really undertake their role with some sense of competence, perhaps they are offered a better job

omewhere else for a much higher rate of pay. So we are continually faced with having to staff our programs with, let's say, less experienced people than we would wish.

I think this is not unique to Kinark. I think you would find this fairly common among the centres, particularly in areas where we are facing fairly high costs of living and people just cannot afford to continue to work in children's mental health for extended periods of time despite their best principles.

Mr Owens: Finally, if we get to the issue of continuity and quality, and it almost sounds like you wrote my script for me here today, if you could address that issue of continuity where, if you have a 30% staff—to me, that is completely ridiculous; you cannot have any level of continuity with a turnover rate that high.

Ms Lewis: That is right, and it is a problem for the children who are in treatment. It is a problem of credibility or families because if you are the parent of a child, you continually have to tell your painful story over and over again and you feel like you are starting from point zero.

Mr Beer: Mrs McLeod had to leave but she said to express her regrets as a former Kinark employee and board member, so you are right, she was very involved with your organization.

Mr Jackson: She took a pay cut and went into politics.

Mr Beer: That is right.

I was interested in your comments about economic incentives in encouraging cross-sectoral programs, inter-agency work and so on. When you look at the players in the field at the local level, I think one of the things that has been addressed today—I know you have studied and listened to a number of presentations—is how we organize on a local community level, however we define it, whether it is a region or several counties.

What would you like to see at the local level? Would you want this to continue to be the Ministry of Community and Social Services that is making those financial decisions through its area or regional offices, or do you think there needs to be some kind of local children's authority, community services, council—however you want to define it—that would perhaps be allocated an amount of money and then you and those active in the field would determine, whether on a multi-year basis or a year-to-year basis, how those dollars should be expended? How do we approach that from the local level?

Ms Lewis: I think it is both/and, and I liked very much the response Dr Maloney gave around a centralized beginning with local authority. I think it might be well worth while for us to attempt to define what minimum services would be required in all communities—this would include such things as child protection services, children's mental health services, education services, recreation services—and then leave it to the local players as to what the variations and computations locally would be, so long as those minimum standards are met, that there is some level of mental health service funded, some level of child welfare funded, some level of education funded, and so on.

I think there are various creative ways that that could be played at the local community level, but there has to be some central control, otherwise it is going to get skewed. We have all heard some of the worst examples of local decision-making. There are also some very good ones.

There is one other thing around the earlier part of your question in terms of incentives. Maybe we could begin with some preference being given for any kind of new initiatives to proposals that are signed maybe by three agencies or three organizations or intersectoral kinds of proposals rather than only uni-agency kinds of proposals and funding increases. So if Kinark and the board of education, and perhaps the children's aid society in a local community, come conjointly and say, "Look, we've worked together and we think this is one way that we could respond in Durham, in York or wherever," that there be a higher priority given to those collaborative kinds of proposals than to singular proposals from organizations.

Mr Beer: I think just in closing, if one looked at the proposals made to the ministry under the Better Beginnings, Better Futures program, that indeed there were many that were from a variety of groups, and I think, if I recall the group that was looking at all the different proposals, that one recognized that there were far more that ought to be eligible and that one wanted to fund. There just were not the dollars in the first go-round, yet there were some really first-rate proposals that in a sense did a lot of the things that you talked about in your proposal.

Ms Lewis: Certainly they bear a second look, but at the same time we cannot jeopardize these services that now exist because we cannot see a further erosion.

The other creative response under the former government was some of the initiatives under the Premier's Council. There was a school mental health project funded that had many of the requirements that are being spoken to in the Children First document.

The Vice-Chair: There being no further questions, I would like to thank you for making your presentation today and wish you well.

Ms Lewis: I thank you for staying so late to hear us.

The Vice-Chair: It is all in a day's work.

Before everyone leaves, I have a couple of reminders.

Tomorrow's committee session will begin at 9 am sharp. As per our agreement, we will proceed even if we do not have all three parties appear. I hope that does not mean no one will show up at 9 o'clock sharp, leaving me to hold the bag. That is the first thing.

Second, as a result of the inclusion of two additional groups to our format here, we will be now going to have an hour and a half for our recommendations towards writing our report with our research officer, so that will take place on Wednesday between 2 o'clock and 3:30 pm. That is a revision. We had two hours scheduled previously. We are now going to have to cut that back to an hour and a half, which I am sure delights our researcher. That is life with respect to standing order 123.

The other thing is we would like the subcommittee to meet on the following Monday 21 January before we have

the final drafting of the report presented to the full committee, which will take place at 2 o'clock or start at 1:30.

Clerk of the Committee: No, 2 instead of 1:30.

The Vice-Chair: Right. We will start at 2 then as opposed to 1:30 and the full committee on Monday 21 January. We will start at 2 as opposed to 1:30 because we only have a half-hour left to us to deal with recommendations for the full committee to hear the final draft of the report.

As a result of that, I think it is good for the subcommittee to meet that Monday, perhaps at lunchtime or in the morning, to deal with crossing the t's and dotting the i's and making sure that the report is at least near ready for

the full committee to then look at and approve final recommendations.

We simply do not have the time to deal with it in full committee.

Is that acceptable to all members?

Ms Haeck: So you were suggesting we start at 2 o'clock instead of 1:30?

The Vice-Chair: Right.

If it is not acceptable, we can scream at the House leaders and bring a motion forward and the full House can deal with standing order 123. That is the only alternative we have.

The committee adjourned at 1720.

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Tuesday 15 January 1991

**Standing committee on
social development**

Children's mental health
services

**Assemblée législative
de l'Ontario**

Première session, 35^e législature

**Journal
des débats
(Hansard)**

Le mardi 15 janvier 1991

**Comité permanent des
affaires sociales**

Services d'hygiène mentale
pour enfants



Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 15 January 1991

The committee met at 0902 in committee room 2.

CHILDREN'S MENTAL HEALTH SERVICES

Resuming consideration of the designated matter of Children's Mental Health Services pursuant to standing order 123.

TIKINAGAN CHILD AND FAMILY SERVICES

The Vice-Chair: Order, please. Our first presenters this morning are the Tikanagan Child and Family Services, Sioux Lookout. Charles Morris, the executive director, is presenting. Please come forward and take a seat. Would you also introduce the person who is with you.

Mr Morris: Good morning, ladies and gentlemen, members of the standing committee. Ruth Roulette is the co-ordinator of services for our child care agency. I am the newly hired executive director.

The Vice-Chair: Before you get under way, I just want to take this quick moment here to remind you—I am doing this with all our presenters—that we have to adhere to the strict rule of a half-hour for each presentation. You have a half-hour from this point on.

Mr Morris: I have a 12-page presentation. That will take about 25 minutes, I believe.

The Vice-Chair: That would leave you five minutes or less by members of the committee. Usually most people who come before the committee would make their presentation and allow 10 or 15 minutes at the end of it, but whatever way you would like to split that up is your decision.

Mr Morris: I am pleased to have this opportunity to appear before the standing committee on social development. I am particularly gratified at this time that you have chosen to examine the issue of children's mental health services and to hear the views of our agency on this vital matter.

It is my understanding that your committee has convened to consider a number of pressing matters that affect children province-wide, such as pressures upon treatment placements and existing mental health centres, the growing numbers of difficult-to-serve children in educational institutions and the need for a co-ordinated policy approach to effect a more accessible and qualitative service delivery system.

While our communities share in these fundamental concerns, I must emphasize the degree to which these needs become amplified in the north, and moreover, considering the virtual void in services to on-reserve populations. In considering the statistics of youth suicide in the past two years, we can conclude that this growing trend of childhood apathy and despair is claiming our children's lives at the rate of one child per month. Further into my presentation, I will provide more detailed statistics on the

suicide epidemic throughout the Nishnawbe-Aski Nation. I think you will agree with me that the picture I present is a disturbing one.

As the executive director of Tikanagan Child and Family Services, I am here to present our concerns as they relate specifically to the unique situation of native children's mental health needs and the limitations we have encountered in that area. Although our agency has assumed the primary mandate of child welfare for the 28 Nishnawbe-Aski Nation communities within our catchment area, we have only begun to scratch the surface in fulfilling the commitment to our people to promote and implement healing mechanisms that will reduce the dependency on protective services for children and families. I would like to provide you with some background on our organization and the unique features of the people and area we serve.

Tikanagan Child and Family Services was created as a result of the signing of a memorandum of agreement between the government of Ontario and the Nishnawbe-Aski Nation in August 1984. The memorandum provided for the takeover of child and family services by native people and therefore restored control over the care of our children and families to our people. This memorandum of agreement was signed by the Deputy Minister of Community and Social Services for the province of Ontario and by the Grand Chief of the Nishnawbe-Aski Nation and by six tribal council chairmen.

This agreement for the first time opened the door for us to begin to offer services to our communities. Under the legislation, namely, section 10 of the Child and Family Services Act, 1984, recognition was given to our unique approach of providing child and family services in the holistic manner envisioned by our people.

On 1 April 1986 Tikanagan became recognized as an approved agency under provincial guidelines. Tikanagan was approved to deliver community support and child care to its member communities. By 1 April 1987 Tikanagan was prepared to take over the child protection mandate and was subsequently designated as a children's aid society under the Ontario Child and Family Services Act. Tikanagan therefore is in the midst of its third year as a fully mandated child and family organization. It is one of the few organizations of its kind in Canada serving both a majority native population and a minority non-native population.

This majority is comprised primarily of some 12,000 Nishnawbe-Aski Nation members over geographic boundaries that span an area of 250,000 square miles. The cost of providing service to this expansive area where air travel is the exclusive means of transportation to all but two of our communities is by necessity very high, but remains a vital characteristic of our work.

Notwithstanding these physical challenges, as our people began taking over the responsibility of child and family services we saw that it would not be an easy task. We began to see that taking responsibility for our children meant delving deeper into the ills of years of systemic ineptitude inflicted upon what was once a vibrant and thriving people. This pathology more intensely affects the younger generation among our people.

In many of our communities we have struggled with community-wide breakdowns and crises. These have stemmed from intergenerational solvent and alcohol abuse, widespread incidents of child abuse, an epidemic outbreak of youth suicide and disturbing elements of cult-type behaviour in some of our youth.

These behaviours are symptoms of the destructive forces of dependency and powerlessness that are entrenched at a systemic level in our communities. On a larger scale this is the root cause of the tragedies we see among individuals. The problems of our communities must be addressed in this wider context with a commitment to lasting change.

Our leaders have thus committed their energies to bringing about self-government for our people and that struggle will continue until the objective has been attained. In the meantime, the struggle itself continues to take its toll in situational terms of personal losses and tragedies. We continue to witness a day-by-day phenomenon of people internalizing their powerlessness through destructive living. The most painful and bewildering of these acts has been the recent rash of suicides by young people in our area. Frighteningly, the statistics continue to increase and at the same time the average age of victims lowers.

The recently published Nishnawbe-Aski Nation report entitled *To Sustain a Nation on mental health policy consultation cities*: "In the two-year period, 1987 and 1988, there were 165 suicide attempts and 13 completed suicides. As of June 1990, there were 76 attempted suicides and as of September 5th, 1990, eight completed suicides. In 1987, most of the suicide victims were young men between the ages of 14 to 25 years. Between 1987 and 1989, the average age of the suicide victims dropped from 23 years to 17 years. In 1990, of the eight completed suicides, three were female victims, ranging in age from 13 years to 22 years in age."

0910

Another serious problem we are facing in this field is the rising number of reported cases of child abuse to our agency. It is a widely held belief among our people that the abuse inflicted upon previous generations due to the old policy of removing Indian children from their homes to the residential school setting prior to the 1960s is one of the root causes contributing to today's lack of parenting skills, especially where neglect and abuse is an issue. In the area of child abuse we must begin to address preventive mechanisms such as community education, which would permit communities to deal with an issue that is both fearful and fraught with interfamilial dynamics among small and closely knit communities, especially in cases of sexual abuse and incest.

As a child welfare agency, we are steered towards dealing mainly with the investigative aspect of abuse and ensuring the protection of children rather than focusing on the healing aspect that is so critical to breaking the cycle of abuse.

In our experience as a child protection agency, we also become involved in issues where the health and the justice systems overlap, where gas sniffing among children is concerned. Time and time again in these cases we find major difficulties in serving these clients due to lack of treatment facilities that do not further alienate the child because of a lack of focus on native children and geographic distances. We have failed to find suitable treatment placement for these children, as well as for those who suffer from long-standing abuse cases. This scenario is similar for those of our children who suffer from schizophrenia and who are otherwise socially maladjusted.

Presently our children are sent to urban centres where services can be accessed, but at a considerable cost both in financial and human terms. The wisdom of this practice is questionable, especially when front-line workers in these settings have confided in us their feeling that the services they provide may be inappropriate to our clientele and indeed detrimental to their mental health. We aptly recognize that children in our area are a high-risk group. However, due to this fact the existing services remain stymied at a crisis intervention level even when prevention remains part of this agency's mandate.

Other service providers in our area share in this sentiment in striving to provide service to children. The services which are provided tend to be fragmented, stemming from the lack of a clear mandate for any one body to assume responsibility for on-reserve-focused children's mental health and concurrently the lack of a strategy that would address other issues such as prevention, service coordination and the need for specialized training.

One of the key barriers to the provision of services is the jurisdictional question of who assumes responsibility for developing an on-reserve program delivery framework and a policy that would support the financial and statutory mechanism required.

Under subsection 92(27) of the Constitution Act it has been concluded that the provinces have jurisdiction for health, while subsection 91(24) of the Constitution Act and the National Health and Welfare Act of 1945 gives the federal government responsibility for ensuring that natives have access to health care.

Furthermore the 1965 welfare cost-sharing agreement in Ontario provides for the reimbursement of on-reserve services in Ontario by the federal government up to 95 cents on expended dollars for services such as child welfare, homemakers and general welfare. To this end, under the child welfare mandate, Tikinagan has been actively pursuing a strategy of accessing a number of children's services that would approximate the function of a community-based counselling unit specifically targeted for high-risk children and families. This strategy, although lacking a policy framework for children's mental health on-reserve per se, would serve to alleviate some of the pressures and limitations facing service providers in our

ea who are acutely aware of the gaps in the children's services field.

Although we are gratified that we have recently enlisted the co-operation of the Ministry of Community and Social Services in this strategy, it is to our dismay that this as only gained acceptance after three years since the original proposal was submitted. At the same time that this as going on we began hearing about the newly launched northern initiatives program, presently known as integrated services for children in northern communities. This program augments the existing northwestern Ontario service delivery to children with special needs through an inter-ministerial approach of sharing resources. Among the services being offered will be mental health related expertise and services.

Again we find that what has been instituted is inappropriate for northern reserve needs. The program designers have told us in no uncertain terms that on-reserve communities are ineligible for professional services which are otherwise available to the rest of the population. This northern children's program has not strategically considered how it will offer service to remote native communities in northwestern Ontario. This omission in planning and the inherent jurisdictional questions associated with it has reaffirmed the necessity for our organizations to press for a comprehensive mental health policy that can meet a wide range of needs in a holistic fashion, serving both adults and children in a community-based setting for Indian people.

At present, service delivery, where it exists, occurs mainly on a reactionary crisis basis. We cannot help but think that in an ideal proactive climate the counselling unit which we are only beginning to set up in our agency could have played a role in preventing some of the losses in our communities if recognition was provided before the youth crisis in our area evolved to the proportions it is today.

We also speculate on the effects of our limited accessibility to community-based mental health programming. Some of this programming through the Patricia Centre for Children and Youth, a Sioux Lookout based children's mental health service, is available to our clients on a waiting list basis if we are willing to remove them from their home communities and families. Our workers must weigh the trauma upon the child of taking this action versus the decision of leaving families intact but without treatment services.

The lack of a mental health policy and program delivery framework will continue to perpetuate the conundrum of community services existing just beyond the reach of on-reserve populations. For those who access them, they will often find themselves alienated because services are ill-designed for serving Indian clients, and the federal government while maintaining responsibility for access to health care will point to funding considerations in maintaining small-scale and understaffed projects such as the Indian Counselling Unit in Sioux Lookout.

It is our position, and one which is supported by the chiefs in our area, that a national policy on native mental health for on-reserve Indians must be developed and recognized. At the back of my presentation I have given

you recommendations of the Nishnawbe-Aski National mental health policy consultation paper, so you will get that.

0920

In considering the role of the province in this sphere I would like to highlight some of our specific and immediate concerns about the present state of children's services. I would ask that you consider the following concerns in the recommendations of this session:

1. Recognition and increased resources where required for measures such as family violence initiatives at the community level; the suicide crisis line presently being implemented in Wunnummin Lake for the NAN area; various initiatives arising from individual communities that are addressing the youth suicide issue through workshops and community education efforts;

2. Recognition of increased financial resources to service special needs children under Tikinagan Child and Family Services care at 50% to 100% higher levels than regular foster care levels; the cost of providing care to these children, many high risk, continues to place financial strain on our residential services budget despite the recovery mechanisms that we have enlisted from the Ministry of Community and Social Services;

3. The establishment of a treatment facility specifically for solvent abusers and particularly with a native youth component, as this is the main client group;

4. The establishment of specialized clinical treatment centres for native children that are equipped with trained native practitioners;

5. Development and implementation of programs for abusers and their families for rehabilitation and prevention purposes, such as Tikinagan's proposal for a male perpetrators of family violence treatment facility;

6. The need for increased collaboration among ministries and programs to fill gaps in service delivery and ensure efficiency to prevent duplication in services;

7. The immediate necessity of exploring more in-depth strategies aimed at improving the state of mental health and related services to Indian children on reserve.

In summary, I would like to once again emphasize the key role government must play in coming to grips with the crisis in mental health services for Indian children, in particular at the policy level. The type of policy I am speaking of must be consistent and comprehensive enough to address Indian mental health needs and requirements across Canada, but at the same time permit enough flexibility to be workable among other federal and provincial jurisdictions and regional and cultural diversities among first nations themselves. In this way, we will be able to sustain those structures we require in building a mental health infrastructure that is holistically based and therefore ensure cultural applicability. We especially see this action as critical for the children with whom we must entrust our future survival as a people.

The Vice-Chair: We have approximately 12 minutes left in the presentation. Mr Miclash.

Mr Miclash: Thank you, Chair. First of all, Charles, I would just like to thank the two of you for coming down to Toronto with your presentation, a very interesting one.

Something that I have had a bit to do with in the past three years is the program on solvent abuse. I am just wondering whether you are aware of the programs, through the Lake of the Woods District Hospital, offered to solvent abusers, first of all.

Mr Morris: Yes, we have taken advantage of that program and we have in fact sent our clients over to that centre.

Mr Miclash: What are your feelings on that program at the present time?

Mr Morris: Well, it is pretty hard for me to say. I have only been the acting director for two months. But the problem, in general, that we have is that our chiefs and our elders have told us to find alternative means of institutionalization, so that would exclude the program at the Lake of the Woods hospital. They want us to seek funds whereby we would be able to set up our own institutions that would provide relevant therapeutic care to our people.

The two cases that I am aware of where we have sent people to that place that you mentioned are cases where we have intervened and it has been a last-resort measure. I do not know if you got the impression from my presentation that there is a lot of work to be done. We need to educate our people and we especially need to do a lot of work on prevention.

Mr Miclash: The reason I asked the question is because it was my feeling that it was a movement out of the institution towards traditional means of healing and that it was one step in that direction. That is why I asked the question as to whether you were satisfied with that step in that direction or not.

Mrs Roulette: I think the other thing that we find, sending our children to Kenora, is that our children come from isolated communities and even Kenora, to them, is a big city and the adjustment there takes quite a while for them. So in terms of trying to treat a child for solvent abuse, you have to also look at the factor that they are homesick and they are lonely. You cannot treat a person who is homesick and lonely.

Mr White: Mr Morris, I am very impressed with your presentation and, of course, the time it took you to come down and to pull it together.

The holistic approach that you present, I think, is quite creditable. When I look at the kind of services that are delivered in urban communities, we tend to fragment our human selves so much that we lose any sense of continuity and context for our own services. I am certainly pleased to see that you are not willing to give up your whole sense of self and the community context, your native context.

You mentioned the Patricia Centre in Dryden. I believe that is their head office. They have a suboffice in Sioux Lookout, I think, with only one and a half staff people. I have two questions. One is, in what way do non-native supports interrelate with your program and, second, do you make any use of, or have other services like your own

made use of, the native bachelor of social work program? I think that is at Laurentian University.

Mr Morris: This is what is so ironic about Tikinagan. I have been there for two months. It seems to be a native child care agency in name only. The native supports that you inquire about, I have not witnessed any of them. The work still has to be done in order to make a bona fide claim that Tikinagan is in fact a native child care agency.

At the local level, where we have our band family services workers, you have to recognize what they are. I do not know if you could even call them paraprofessionals but they lack the training to do the work that is required of them and Tikinagan in no way has the resources or the capability to provide the training that is required in order to make the BFSWs an important linkage between the reserve level and our core office and so forth. So there is a lot of work that needs to be done. I do not know if Rut would add to that.

Mrs Roulette: In terms of the Patricia Centre in Sioux Lookout, we do use the support system. However, the Patricia Centre does not service anyone north of Sioux Lookout, so we have to bring our children out and that has a tremendous effect on the children when we bring them out of their communities.

Mr Morris: We are just an intermediary. We purchase service from other institutions and from other groups, and that is all we are presently. That is the sad fact about this whole operation.

Mr Jackson: Really briefly then, Charles, thank you for your presentation. In the six years that I have been here I have listened to a lot of submissions from native bands in the social policy area and I keep coming back to the scary statistic that something in the order of 2% to 3% of the entire native population ever gets inside a university in this province. Perhaps that seems to hit on the point that the process of healing within your own community has to be done by native peoples and, as a result, if we are not providing the educational opportunities, then you are going to always be in a position to purchase service from outside your community, which is not part of the process of healing. I guess it is more a statement than a question but I would like your response to it.

There are several reports from legislative committee identical to this one, which have investigated this issue and made some very clear and strong recommendations for native education, so that your resource pool is larger so that you can be empowered to deal with your own concerns. Would you please respond to that, because it seems to be part of the problem that you are struggling with?

0930

Mr Morris: The problem lies to a large fact that when Canada was created the provinces and the federal government sat among themselves and totally excluded native people from any sort of empowerment, as he called it. So there is that jurisdictional problem. I think a lot could be solved, a lot could be done by native people if only they would receive more self-government powers from the two levels of government. That is to a large fact one of the main things that has stymied us time and time again. There

no policies in place. There is always the jurisdictional wrangle. There is always, always that jurisdictional void between the federal government and the province, so they keep passing the buck back and forth to each other, despite what our treaties say. The provincial government does not give a damn, the federal government does not give a damn. Until that attitude changes, nothing is going to improve for native people.

Mr Martin: It has been my experience over the years, having spent some time with native people, that we have a lot to learn from you in terms of how we deal with each other and with our children. I am particularly interested in the holistic concept. You also mentioned integrated services. Certainly it sounds, from some of the witnesses we have had here to date, as if we need a more comprehensive, co-operative approach to this whole thing. You mention they call it holistic. Perhaps from the native perspective, you might share a little bit more with us what you mean by holistic.

Mr Morris: Holistic, I do not know. I guess basically what it means is that native people be given more of a say, like the utilization of traditional means of resolving problems.

What I could say is that, with regard to treatment, the efficacy of treatment is directly related to the socialization of a person has been brought up in, that particular social environment that he or she has been brought up in. So we bring our kids out to a totally foreign setting where they are totally immersed in foreign norms, behaviours, traits. If we had our own native practitioners manning our institutions, I am sure the treatment would be much more successful. We have to develop our resources, we have to develop a framework, but the government, first and foremost, has to come up with the necessary policy and resources and the two levels of governments have also got to define their jurisdictional powers in relation to what it is that we want. That is what I see the holistic approach as being.

The Vice-Chair: We have run out of time. I would like to thank you for making this trip to come before the committee. You have come a long way.

Mr Owens: I am wondering if it would be possible to obtain a copy of Mr Morris's presentation.

The Vice-Chair: Yes, I neglected to tell the committee members that we are trying to do that at this very moment and we will be distributing that as soon as it is available.

LAKEHEAD REGIONAL FAMILY CENTRE

The Vice-Chair: I would like at this point to call our next set of presenters, the Lakehead Regional Family Centre from Thunder Bay: Dr Kevin Nugent, child and family psychiatrist, senior clinical consultant.

Welcome to the committee, Dr Nugent. We will just get settled down here and you can start your presentation. Again, I remind you, as I will do with each of the presenters, that you have half an hour for your presentation and it is your choice as to how you divide that. Your

presentation can make up the entire time or you can allow for questions within that half-hour period.

Dr Nugent: Thank you, Mr Chairman. It is a pleasure and an honour to have the opportunity to address your group. This is as close to a political process as I have ever come and I really feel complimented to have been given the opportunity to make this presentation. I also am reassured that in these times when people are so cynical about political processes, the concerns about the children's mental health centre that had been brought forward over the past year or so are being listened to and are being attended to, and I assume this is part of the process in dealing with those problems.

In my presentation, I am going to assume that we are primarily at the level of trying to identify what the main concerns and underlying causes are in terms of problems in the children's mental health centre, rather than to be so presumptuous as to lay on solutions.

I also want to make it clear that I am speaking primarily as an individual and as such I would like to indulge by telling a little bit about my background. I am a child and family psychiatrist, which is to say that in addition to medical training and training in adult and general psychiatry, I have specialized in working with the mental health problems of children and adolescents and families. I have moved through the province, and so I have some sense of what the systems are like in other communities. I have worked in Kingston, I have worked at the Children's Hospital of Eastern Ontario in Ottawa, I have worked at McMaster and at Chedoke in Hamilton, and I am very pleased to see that one of my mentors, Dr Offord, will be addressing you this afternoon. I also finished off at the Hospital for Sick Children and another one of my mentors, Dr Bradley, is also on the program today.

I made a very explicit decision at the end of my training to strike out to the frontiers, to leave the health science centres, to leave southern Ontario and to go to northwestern Ontario, and up until very recently I have been the only child psychiatrist for the quarter million population in our area.

I have affiliated myself with the main children's mental health centre, the Lakehead Regional Family Centre, and I have functioned very much as a consultant to try and spread myself around there. So at the case level, at the team level, at the program level, at the agency level, where I work with our managers and even our board, and also at the organizational level across the area, I have tried to function as a consultant and work with our district health council. I am presently involved with a major project that is reviewing the way in which our regional services are offered across the entire mental health system. I am on the steering committee for that group. And finally, I am affiliated with the University of Western Ontario, which has set up a program—it is called the extended campus division of the department of psychiatry—trying to sponsor psychiatrists across the north. At the present time I stand as the only Canadian-trained psychiatrist within that group of psychiatrists across the north, and I will try and make some reference to that as I go on.

Again, I want to make it clear that while I have talked to a number of my colleagues, including some within our agency, this is mainly my own stance that I am presenting to you. I will move on to the paper. I believe that you will have copies of it, and I will move right to the section regarding quality. I am going to deal with the headings that you have talked about.

I see an apparent failure to value quality of service and programming in children's mental health, and I am afraid I trace a major change to the switch in 1977 to—I am used to calling it Comsoc; maybe it is more polite to call it MCSS, but I am afraid I call it Comsoc throughout this—Comsoc taking over care of child mental health centres. I see since that time a real devaluation of several areas, first in terms of clinical direction and expertise. Many child mental health centres have what I feel is an ill-advised lack of clinical leadership and direction to complement the administrative structure.

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We are used to seeing in health and in adult mental health systems positions like a clinical director, a medical director, a psychiatrist-in-chief. While I would feel I have moved away a lot from a medical model in the sense that the psychiatrist has to be in charge, I believe very strongly that someone with expertise has to oversee the clinical direction of our child mental health centres. That is true in some centres, particularly the academic ones down south, but as you move away from that and into the smaller centres, I think that is often overlooked.

Subsequent to that, I think there is an inadequacy of skilled attention to clinical training, to program planning and development, to quality of service and to clinical research. In a meeting in our centre recently, the main unit of our centre, I found out, did not feel it was necessary for its staff to do assessments and treatment planning at the time of getting involved with their cases. That is the kind of situation that would never happen if there were stronger clinical direction. My role in our centre as a consultant means I do not have any formal authority or direction. I merely give my ideas as a consultant.

Next, I feel that the directives we have got from MCSS, such as Investing in Children in 1988 and in the north, Northern Directions for the Delivery of Services to Special Needs Children and Their Families, are naïve, conflicting and seem to lack a sound expertise about the business, about clinical expertise and treatment and about what our present system of care is. I also see a profound failure of the CMHCs to offer adequate training, supervision and salary to a largely novice staff with the rare exposure to sound academic training in terms of their university training to child and family mental health issues.

I feel that, first, our universities are not doing a very good job of turning out graduates to be prepared to do good work in child mental health and, second, child mental health centres have become a training ground for our new grads. They come and work and we train them and then they go on to work in other sectors where they are better remunerated, and I will come to that.

I also see a real movement away from the idea of clinical assessment and treatment towards more of a care mentality

as you see in the child welfare system or probation services. I feel that the Comsoc administration of CMHC shows very little understanding about clinical concepts. I also strongly resent, and I know a number of my psychiatric colleagues have tried to speak about this, this idea of redefining what we do in child mental health as intervention or support to try and access the Canada assistance plan funding. This has been going on for a number of years and is even now in legislation I understand.

I also see, and I do not know if this is only a northern phenomenon, a kind of amalgamation mania which has to do with joining programs to virtually everything in sight which includes things like care and support programs, children's aid societies, and so on. I see a real blurring of boundaries and a confusion and this also ends up diluting the clinical strength of the programs. As I said, I do not know if this is only a northern phenomenon. I am particularly against the idea of amalgamating children's aid societies and child mental health centres, because I think there is a very real boundary there that is very confusing for our clients when those are merged.

Then I see Comsoc's unwillingness to pay appropriately for clinical expertise at the staff and program levels. At the staff level, recently our centre has lost two very good MA psychology people, psychometrists. One went to the health sector with a \$6,000 raise; one went to the education sector with an \$8,000 raise and the summers off. We cannot compete with other sectors on these kinds of circumstances.

At the program level, I would like to say something about our experience in Thunder Bay trying to procure a community-based treatment program for assessment and short-term treatment of adolescents. We have been proposing such a program for six years. We have undertaken two or three surveys. There is unanimous support across all sectors for such a program. We have customized our proposal to meet local need. We have rewritten our proposal two or three times. Basically we are being told that a clinical unit is too expensive.

About three years ago, the native child mental health centre in our area decided to go ahead on the budget that was being proposed. They have recently been reviewed and basically that review said: "This is a group home. This is not a clinical treatment centre." We have reappealed; we have scaled down our proposal on every possible opportunity that we can find.

This is at a time, incidentally, when at last count—my director did a survey—75 adolescents from our region were sent to out-of-region residential treatment over a one year period at a cost of hundreds of thousands of dollars. We are still told that our proposal is too expensive. Basically they want a group home; they do not want a clinical treatment centre for assessment and short-term treatment of adolescents.

Finally, I am concerned about the linkages to the health sector in this area of quality. I am talking about general hospital services, addiction services, adult mental health, paediatrics and family practice. I see a real lack of needed communication and co-operation. Recently in my centre for example, a number of our managers argued with me

about whether it was "worth the trouble" to update family physicians about our work with their patients. This shows an attitude of a major schism between us and the health sector. There is occasional duplication of services. We do not see that often in the north. Serious gaps in service result in many children and families falling through the cracks. This particularly happens with adolescents, I feel.

Next I will move on to the issue of accessibility. If you will indulge me in a mini-lecture, these are terms that may have come before this committee. These are quoted from one of the major textbooks in psychiatry. "Primary prevention aims to eliminate a disease or disordered state before it can occur." So this is true prevention. "The goal of secondary prevention is to shorten the course of illness by early identification and rapid intervention." Here we are talking about treatment or cure. "The goal of tertiary prevention is to reduce chronicity through the prevention of complications and through active rehabilitation." So here we are talking about maintenance, support, rehabilitation.

I would maintain that in Ontario, our child mental health centres typically pay lip service to primary prevention and deflect or put on waiting lists many of our opportunities for secondary prevention of child and family mental health problems. If primary prevention is so important incidentally, why do we so devalue secondary prevention?

I also see an inordinate amount of our resources going to well-established and highly resistant presentations where we are essentially involved, by these definitions, in tertiary prevention. This list of presentations is really the main work that our centre appears to be doing at this time: children from abusive and neglectful homes, children from alcoholic and other kinds of serious dysfunctional families, incest victims, disturbed adolescents with conduct disorders and emerging personality disorders, children with autism.

It is not that I do not feel that we should be involved in the treating of these disorders. I do feel that by concentrating most of our resources on those, however, we are missing all kinds of opportunity for secondary prevention, for preventing children and families getting to some of these states of severe and entrenched disorder.

If I were to make a medical analogy, and I think you will be aghast, imagine you phoned your paediatrician and said: "I'm calling about the young one. He's running a temperature and he's got a terrible cough. It sounds like there is a bit of a wheeze." Imagine if your paediatrician said: "You know, we're awfully backed up with our ICU cases and our rehab cases. If he gets really sick bring him in, but otherwise he's just sick, so don't trouble us with it." That would not be acceptable; that would be a legislated impossibility. This is the kind of thing that is happening in child mental health, which really makes one wonder about what value we place on this area.

With the kinds of presentations which I see more in the area of tertiary prevention, we are often doomed to rather limited success, because we are looking at situations where there may be limited resources and motivation of the child and family, inadequate clinical skill of our staff—remember

we have a very young, green staff where training has not been emphasized. There is a lack of intensive treatment structures and settings.

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A good example of this is in the area of sexual abuse, where we have a sense now of how we can properly treat families where incest has occurred, but it calls for a comprehensive, well-co-ordinated system that most child mental health centres are not able to provide.

Also, I see a weakness in our systems in contending with chronic conditions, situations and rehabilitations. We are dealing with chronic situations as if it is a matter of quick treatment and cure when oftentimes there may be a need for relatively long-term support and intervention.

I guess the one area that I would point to where this contrast is most striking is dealing with the contrast between the young offender sector, which at least in the north in my jurisdiction has received a major influx of funding over the last few years, and dealing with the kinds of kids who end up with young offenders earlier on, for example, children with attention deficit disorder and hyperactivity. As many as a third to half of those kids go on to have trouble with the law. Many of those kids end up in the young offender sector.

I have done lots of young offender assessments. Many of those kids had hyperactivity and attention problems that were not diagnosed, that were not well handled. In our centre, I have been trying for a number of years to get some designated resources to put in a program for children with hyperactivity, while we have a whole team dedicated to the young offender sector and, as I said, lots of other resources coming into the young offender sector. So we have no sense of a stitch in time here. We are putting major resources in at a point in time when it is well known that treatment of well-entrenched conduct disorders is a very frustrating and limited exercise.

I would also like to make a comment about the 10,000 or so cases awaiting child mental health services. I would ask, should not mental health assessment certainly, and at least perhaps treatment where indicated, be a legislated right in Ontario?

What of the opportunities for early identification and treatment that are being missed as families turn away bitterly from interminable waits? Should we wait for the entrenchment of presenting problems for suicide gestures, family breakdowns and so on, before our citizens have a right to mental health assessment assistance?

Next I would like to move to the issue of availability. I see a need to recognize that there should be a spectrum of services from basic services through to specialized services available according to the realities of population and the region. This has been well documented in many reports going back to the Heseltine report and others. Why are we not following our own guidelines in these areas?

Speaking on behalf of my area of northwestern Ontario, our critical needs would include skilled emergency assessment and short-term in-hospital treatment resources in at least one general hospital. Adolescents going into hospital in our community do not receive any kind of quality service on a reliable basis.

Second is the kind of community-based crisis and short-term treatment facility for adolescents I have talked about.

Third, and this is something that is kind of a new idea, is a pool of funds available to flexibly meet the needs for creative programming in special situations.

One of the youngsters that I have been involved with, for example, is about turning six. He has behavioural problems, and his mother was coming to keep an eye on him over lunch. She had an opportunity to return to the workforce and this boy was not able to manage through lunchtime. He was suspended three times and was on the verge of expulsion from kindergarten. A very small amount of money would have been able to provide some opportunity to supervise this child over the lunch hour. That is a small example of what I am talking about.

Finally, and I say this with little trepidation having talked about how money is flowed to the young offender sector, it is clear to me that there ought to be some kind of a prevention resource for intensive treatment of high-risk young offenders before the major offences that we are anticipating, before serious assault, before further sexual offences, and so on. When we call the supposedly designated centres in Thunder Bay, we are told they have not done that offence yet so we cannot get them into the treatment programs.

I would also like to suggest to you that a well-functioning child mental health system requires adequate backup from child psychiatry, from adult psychiatry and from the adult mental health system.

I would like to ask when the government of Ontario is going to contend with the drastic maldistribution of child and adult psychiatrists in the province. Why should we in northern Ontario with a population of 833,000 be struggling with a little over two dozen psychiatrists and three onsite child psychiatrists when at the other extreme Ottawa has well over 200 psychiatrists and well over three dozen child psychiatrists? When is this issue going to be confronted?

Regarding funding, I recognize that there is not likely to be a major influx of new dollars into CMHCs, although I do feel the sector is underfunded, but I do think some realities have to be faced. Our local Comsoc office continues to nickel and dime us on what are even very basic base budget issues, often coming from its own directives, the amalgamations it puts us through, pay equity and so on. This can only lead to cutbacks in service and training and a very real demoralization of our staff.

Second, in regard to the major salary discrepancies between CMHCs and virtually all other sectors, we are seeing a very real and rapid turnover of staff, a loss of experienced staff and again demoralization. Quality clinical expertise, treatment and programming cannot be purchased at rates that you would expect to pay for care and support and for group homes.

In conclusion in this area, I really feel society will get what it pays for. A continued failure to invest wisely in the mental health needs of children and families will only put increasing burdens on corrections and adult mental health services as our children grow up, and on education, child

welfare and child mental health services for future generations.

The Vice-Chair: We have approximately 10 minutes for questions. I have on the list Mr Owens, Mrs McLeod, Mr Beer and Ms Haeck, in that order. Mr Owens is first.

Mr Owens: I would like to begin by thanking Dr Nugent for his presentation. I think you have delivered fairly round and sound condemnation about the system as it exists now. I am wondering if you can present to the committee some specific recommendations that we can take into account as we go forward to bring recommendations to the government. I guess you are currently based somewhere between northern and southern Ontario, and what we heard from different presenters over the past day and a bit is that there are unique problems related to both sides. I am wondering if you could comment on that and also give us some sort of guidance as to what we should be looking for.

Dr Nugent: As I said, I was not certain that my vantage point and my definition of the problems coincided with the issues across the province, although I have some sense of those things. So I will make a couple of thoughts that I would see more as directions rather than solutions.

I think we really have to look at the decision we have made in terms of how the child mental health centres are administered. Is the MCSS the proper place to do it? Should it perhaps be Health? Should we look at the creation of a ministry for services for children and youth? I really feel that issue has to be struggled with. If we remain under the administration of MCSS, then we really need to get some people who have a knowledge of mental health and child mental health in positions of authority in MCSS.

I also feel very strongly, and it is an understandable bias, that the issue of clinical direction and expertise and informing of our programming and our training and so on has been undervalued and needs to be contended with on a centre-by-centre basis.

I feel some of the basic funding issues, as I mentioned in the summary, really need to be dealt with. One of the issues that is clearly an issue in the north has to do with recruitment and retention of professionals. The financial issue makes it that more difficult to retain professionals, but we find it very difficult to recruit MSWs, MAs in psychology, PhDs. We have only a single graduate-level program in northwestern Ontario, which is an MA in psych program. They do not even have a course on child mental health. We really need to look at ways to improve that in terms of the situation in the north.

In our area, the native child mental health services are in a rather independent structure and function, so I am circumspect in what I have to say about that sector, but I tend to lean towards the idea that they really need to have culturally sensitive and appropriate services. The kinds of clinical offerings that I have been trained to give often do not jibe with where particularly native children and families from very traditional ways are coming from.

Those are some things in terms of solutions. Perhaps others will come up as we move through the discussion; there are a lot of questions here.

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Mr Owens: In terms of the cultural sensitivity issue you raise in northern Ontario, how would you build that into the medical model that you seem to feel is the route we should be going?

Dr Nugent: Are you talking specifically about the native mental health sector? I feel very strongly that it is a situation of people with clinical expertise being available consultants to native health providers, that we should be involved in training and supporting, consulting to them, raising their level of expertise and their knowledge of various aspects of technique of our area in terms of their being able to provide it to their own local people. A system of that kind of support to native mental health providers could quite easily be established. There is something comparable to that working out of Sioux Lookout but more readily available across the north.

Mrs McLeod: I am not going to attempt to take the committee into the whole area of the special needs of northern Ontario. I was most anxious that we have representation from the north so we would begin to get a sense of what a huge area of need it is. I think we really need to focus on it in a very particular way and all we can do in these sessions is begin to get a sense of the enormity of it. Obviously, I am also very biased and not at all objective in dealing with the issue, so it is probably best that I not open it.

But I would point out from the opening comments Dr Nugent made that in his involvement across northwestern Ontario, one of the things I think he did not mention was that the only reason we now have a second child psychiatrist for the first time in my memory is because of his personal effort Dr Nugent makes to recruit people. That is also something which has been demanding of his time and personal commitment, and it is reflective of the acute need for trained people in northern Ontario that our clinicians would have to make such an effort at recruitment. It is also, incidentally, one of the factors we have to look at in terms of the high rate of burnout for professionals in northern Ontario.

Having made those comments, I will ask Dr Nugent to go into a more general area. The short-term crisis unit you mentioned is a long-standing need and one I am well aware of. I think the fact that has not materialized is not just a funding issue, although that is real, but also seems to reflect the other issue you have addressed in your report, which is a very basic difference in orientation between clinical and support models.

I do not know if you have had an opportunity to look at the Maloney report yet, which was tabled just before Christmas, looking at children's mental health services and recommending essentially that the school become a hub for service delivery. It may be unfair to ask the question before you have had a chance to look at the report, but I am wondering whether you think there is room for some of the primary-secondary interventions, as you have described it in your report, to be possible at that school level with a role still for a clinical referral model at a more centralized level.

Dr Nugent: I believe very strongly in that possibility. I think there is some good research that looks at primary prevention efforts based in the school that are non-stigmatizing, that are available to all children and that can make a very substantial impact. I am talking about Rutter's work in terms of primary prevention in schools in Britain. As to secondary prevention in terms of children and adolescents in school who are actually experiencing difficulties, I do not see why a support group kind of intervention, such as a support group for children whose parents have separated, could not be available based in the school. I am supportive of that as a direction to go.

Mrs McLeod: You are optimistic that clinical and social work models can work compatibly and provide a continuum, that we can get past this basic conflict in approach?

Dr Nugent: Oh, very much so. There is a clear need for a range of services. My difficulty is when the clinical ones are lopped off because they are too expensive or not valued and so on. We need the range, clearly, in my opinion.

Mrs Witmer: I am really pleased to see this very frank and honest report. Following up on what Mrs McLeod has just spoken to, the school being a central focus, would you also support the establishment of some sort of children's services planning advisory committee in each community to help co-ordinate children's services at the local level?

Dr Nugent: Certainly I would. I think it would facilitate the linkages between different sectors. We are making some initiatives in those directions both in the child mental health and the adult mental health sector in Thunder Bay. So far, we have been encouraged by what has been coming of that. Yes, I strongly support that as well.

The Vice-Chair: Thank you for your presentation.

ONTARIO PREVENTION CLEARINGHOUSE

The Vice-Chair: Our next set of presenters is the Ontario Prevention Clearinghouse; Bryan Hayday, executive director. Thank you for coming to the hearing. We have half an hour for your presentation, as I remind each of the presenters. We will stick to that time limit and you can divide that in whatever way you deem appropriate.

Mr Hayday: Thank you very much. The written presentation that has been distributed is not something I will read. I will not, however, introduce significantly different information but rather highlight it in the same sequence in which it is presented.

I would like to begin by making an introductory remark. It is important when we are thinking about the children of the province that we think about all of the children of the province and not just about those whom we are most aware of because of some specific current problems they may have, and recognize that any solutions which work for the few have to be in the context of all children. That is a theme I would like to pursue.

Our vantage point at the Clearinghouse is that as an organization we work with nonprofit organizations and

social services, health and education across the province. So I think we have a rather unique perspective that reflects the interests of children across the province as well as other community concerns. The Clearinghouse has had a history of about five years and it is in that context that I will speak.

Children's mental health has expanded significantly in Ontario over the last 15 years. In some ways, it can be dated back to an experiment to bring together a children's division and solve some of the issues which are surfacing again a decade and a half later. During that same time period, there has been some significant research which we must pay attention to; it needs to be examined in a context of this question as well. That research is drawn in part from the Ontario Child Health Study conducted by the child epidemiology unit at McMaster. That study showed there was an incidence level of childhood psychiatric disorder that ran upwards of 16% of all children in the province between the ages of 4 to 12. Childhood psychiatric disorders are some of the concerns which children's mental centres pay attention to. If you keep in mind that figure of 16%, at the same time that 16% of all children in Ontario may have a psychiatric disorder we have a children's mental health system and children's and youth institutions and other organizations providing children's mental health support seeing maybe 2% of Ontario's children in any given year, with no guarantee that this 2% is drawn from the 16%. We have absolutely no way of being certain that those figures correspond. So even if you as a committee were to recommend an 800% increase in the resources providing treatment services for children with a psychiatric disorder in the province, there is no guarantee, the way we have currently organized our system, that those services, even increased eightfold, would address those children in most need. That is the first point I want to register with the committee.

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I would also like to remind you that while we accept tacitly the importance of access to treatment, we do not demand at the other end of the spectrum any substantial evidence of the effectiveness of that treatment in adjusting the long-term life chances of those same children. There is a kind of lipservice paid to the importance of more access to treatment without equivalent efforts going into demanding evidence that this was useful and helpful for those same children in terms of changing their life chances and improving the quality of their lives.

There are some other disturbing findings that came out of the child health study which are buried in the detail, and this gets us back to the level of looking at the entire system for children. The child health study found that for those children living in families where the principal source of income was a welfare cheque, when you held that income constant and compared it with children living in the families of working poor, the same dollar value, the likelihood of childhood psychiatric disorder was substantially higher in those families where the dollars came from welfare rather than from earnings. Since we know that a substantial life improvement could be realized for those children by addressing that kind of system question, you

have to wonder about the order of priority on which we are attacking some of these problems. The predictive negative impact of welfare dependence on life chances for children is enormous and substantiated by research.

More recently in Ontario we have two reports which asked us to look system-wide, and I would like to ask that you consider those in your deliberations. The Investing in Children report looked at some of these same problems in terms of access, availability and prevalence of problems for children with mental health concerns. One of the more recent reports, Children First, which has recently been released, says we do not have solutions available for children in piecemeal form; that we need models that work at community levels of which children's mental health centres would be partners but not the sole source of the solution; that schools are important; that recreation is important; that health is important; that corrections are important; that the co-ordination of our resources at the local level will yield potentially substantial benefit for those same children.

We have talked previously about the need for an agenda for children in the province. As the growing welfare rolls and waiting lists attest, some substantial difference, a different, fresh approach involving problem-solving at local community levels, fiscal allocation at local community levels, may hold some promise that we have not realized with our current attempts. Doing more of what we are doing now does not hold the promise for us that doing differently does.

Children's mental health centres have shown the potential to increase their community profile, their community presence and their preventive thrust to address problems at source rather than problems which are fully developed, full-blown, such that you have children in significant distress. They are not in distress one day and in massive distress the next. There is a period of development of the problem, within the family, within the community, within the context of understanding the child as a developing creature. There is a logic, there is research, there is an intuition which says we simply must invest our resources in prevention and early intervention as we have no substantial evidence that says we have either the resources or the expertise to deal with the volume of children who have treatment needs.

Children's mental health centres have an opportunity at this difficult time in the sense that they do not have a legal mandate to provide most of their services. They have resources which have an element of community discretion attached to them. They could be delivered differently without any required change in legislation. They could become the vanguard for some of the partnership required in some of these broader-based systemic solutions.

One of the examples of that kind of alternative way of working together at the community level is contained in a model known as Better Beginnings, Better Futures. It is an example of the kind of integrated child development model which has been under development in Ontario for the past three years. Better Beginnings, Better Futures brings together what we know from the research nationally and internationally about what works for children that

nakes for a better future for them. It is a model that we hope, we expect, will be launched in a number of Ontario communities very shortly. This community-wide model engages parents and children as partners, not as recipients of a service, with the various agencies that have a stake in the children's future and brings together again in an integrated manner, not in a sector-separate, discipline-divided manner, the best interests of the children's future. Together, this Better Beginnings partnership should be able to deliver the best of what we know about what can have a substantial long-term impact on children's development and change their life trajectory.

That kind of broad-based systemic approach holds some promise. Doing more of what we are doing now does not hold promise that is based on any substantial research. In fact, the research markers are pointing us in the direction of doing things differently.

Our service system for children in Ontario will always require areas of expertise for children most in need, but it requires a balance in that system. We should not be tinkering with one end or the other. That system needs a balance that puts an emphasis on prevention thrusts based on research, earliest intervention possible and treatment, where necessary, for those who have not benefited from those earlier interventions. But as a province, I think we need to organize our system in the interests of all those children so that we are emphasizing that end of the spectrum where we can have the most effect possible. Children's mental health services have demonstrated a potential to move in this direction. This should be applauded, supported and encouraged in the best interests of our children's future.

Thank you for the opportunity to make this presentation.

The Acting Chair (Mr Miclash): Thank you very much for your presentation as well. So far we have three people on the list for questioning. I will start with Mr Malkowski.

Mr Malkowski: I was very impressed with your presentation. I would just like to focus on the information related to the Ontario Child Health Study. It shows that 16% of children have mental health problems and only 2% receive the appropriate services. I am just wondering how you feel about some development within that area and the legal implications of these services being provided. Do you feel it is important for us to consider the development of legislation that would ensure that these services are being provided in the different areas, for example, children's mental health awareness, to help the parents and the education system become more aware and able to recognize these symptoms as early as possible; the second area, the children's mental health prevention program; the third area, children's mental health educational training programs? I was wondering which of these areas you feel might be the most important, which needs to be really most focused on and most immediately addressed, and where children can get the most appropriate health services through these sorts of issues.

1020

Mr Hayday: I need to make notes, because the question is probing. I will take them in the order in which they were posed. The ministry with lead responsibility for children's mental health services is the Ministry of Community and Social Services. One of the areas of legislation which it attempted to bring forward—did bring forward—was the Child and Family Services Act. There are problems with that act in terms of what is being seen by the field as excessive litigation, a litigious attitude which is interfering with access to services and the quality of services.

There is a working group, of which I am a part, on strategic directions in children's services that is struggling with whether or not the solution lies in legislation or in alternative delivery systems that are not necessarily dependent upon legislation. Making it the law does not necessarily improve our capacity to deliver. That would be my quick overview of the Child and Family Services Act experience.

The second area: In terms of prevention program, I am aware that there is a prevention policy existing in near-completed form within the Ministry of Community and Social Services which has implications that cut across the ministries of Health and Education and which would have service delivery implications. I would urge the government to bring that policy forward and declare it and work through the delivery implications of it. I think that would be a substantial step in the right direction. Our training and education programs are not always well linked to best practice informed by research that shows the effect, size and value of that practice. I think it would be useful to have a continuing education capability that linked service practices to what is known in the research.

I think I covered the questions there. I may have missed part of one, if you would like to redirect me.

Mr Malkowski: No, that is fine. Thank you.

Mr Beer: I think it has not been by design, but I think it has been fascinating to have your presentation after that of Dr Nugent, not because I think the two of you would necessarily disagree. I think it would probably have been most useful for the committee to have both of you at the table right now as we deal with some of these questions.

What I think is important, as a committee, is that we recognize that there have been some approaches to this issue—whether we want to oversimplify and say the medical model and the sort of social service model, regardless of what we may feel about that, the answer surely lies in a better integration of those and that the concerns that Dr Nugent raised are ones, whether children's mental health falls within the mandate of Comsoc or Health or some redesigned system—clearly there are both of these areas. You made reference to Better Beginnings, Better Futures, which it seemed to me in a conceptual form was the way we wanted to go, which brought together the best of the clinical and treatment, the best of early intervention and the best of prevention and tried to approach it in, to use the term we are using, the holistic sense.

I think what I take is that you have identified and Dr Nugent identified real problems. Those are not imagined. They are real and they are there. In a sense for the government, for any government, how do we then organize ourselves to meet those needs?

I know you made reference to the report by Dr Maloney, *Children First*. I realize this is preliminary, but I wonder if you could share some of your thoughts in terms of how we put together structures both at the provincial level and at the local level to try to get around the various roadblocks that we have because of government structures, ministerial structures and all that sort of stuff, so that in fact the dollars that we have, which will always be limited; we will never have all the money we would like to have—but how can we best put that together? Then you will have done the committee's report and we will not have to—

Mr Hayday: In answering your question, I am reminded of the previous question that I missed so I will roll them together.

The governments of Ontario—three different parties—have toyed with models—“toyed” is excessively derogatory—have worked to find models at the local level of spending in an integrated and co-ordinated manner, resources that cross health, education, social service, fiscal budgets and delivery systems.

We have come close a couple of times. We came close with the children's services committee experiments of the late 1970s and early 1980s. We got right up to the decision point in terms of actually allocating budgets and fiscal authority and then we deep-sixed it because we were not quite ready to trust that people could make decisions locally, with all of the resources that were represented, in the best interests of children and services in a way which would not set legal precedents that would cause us inordinate difficulties, etc.

We have come close in terms of bringing together district health councils and local social planning bodies and giving them some kind of local fiscal decision-making capability. We have been within weeks of announcing experiments of that kind and have deep-sixed them.

It seems to me that the situation will eventually get so desperate that we will actually try it. We will actually try somewhere an experiment that makes available all of the dollars and resources, which we are spending in those communities anyway, in some integrated manner where it will not matter what the entry point was for the family with the child with the problem and the concern that they were worried about.

If they are more friendly with the public health nurse or the community health nurse or the children's mental health centre or the teacher, or they happen to know somebody, a pastor, who is on a local planning council, it will not matter what door they walked in because they will not become trapped in a service labyrinth thereafter. They will have walked into an integrated system where they will be able to get from the resources that are available a proportionate share that would enable them to improve their life circumstances.

There is a political will question here because of the three levels of government that fund, ultimately, services at

local levels. But I do not know that our country is big enough to afford three parallel systems that do not work together, much less the ministries that fight with each other around fiscal economy. I think there is an issue of political will and a local community experiment is required.

Mrs Witmer: I appreciate your report and I appreciate the opportunity to become familiar with your organization. You talked about the delivery of service and the problem that we have and that there is no point in throwing more dollars at the system at the present time if we are going to deliver it as we have presently. You go on to speak about the Better Beginnings, Better Futures model. Following through on that model, do you then see the schools becoming a central focus for interagency needs assessment and service delivery?

Mr Hayday: In some communities that may make sense.

Mrs Witmer: What alternatives would you see, then?

Mr Hayday: I think that if we are going to pay more than lipservice to local decision-making, we may need some local forums to decide what the lead agency should be in certain communities, and it will not always be the school. Although the school is easily recognized and may be the dominant entry point for some, there may be some communities where there has been a relationship between the community and the school system that would make that a hostile relationship at this time.

If the system is genuinely going to be flexible, I think we need to be open to exception in Ontario. We have a tendency to want to design systems that work everywhere as though this province is made up of some kind of generic community where a single system will work in North Bay or Marathon or Cornwall or Hawkesbury or Kapuskasing or Scarborough. Our province is not organized like that. So to decree by caveat that it should always be thus, without a mechanism for local flexibility, does not seem to reflect the character of the province.

Mrs Witmer: What other agencies or groups would you then see becoming the central focus? You talk about the need for flexibility. What other suggestions would you have?

Mr Hayday: In some communities, a community mental health program may have an integrated child and adult program. A community health centre may be a local access point; the community health unit may be, and the school. It may be that someone is more familiar with the food bank. I am not recommending at this time that food banks exist in perpetuity, but whatever your service access point is, there needs to be some connection to the rest of the system.

Ms Haek: Mr Hayday, I welcome your report very much. You definitely synthesize in an extremely articulate fashion a number of things that have been discussed, not only here but in my other lives as well, and I am glad you have done it as you have. But I also feel, because of my own experience out there in the real world beyond this building, that you will receive some criticism if we do not get on the record exactly who you are. We have heard from

whole lot of professionals, but according to what I have here I am not exactly sure what your—

Mr Hayday: Credentials are?

Ms Haeck: Exactly, because I am quite sure there will be slings and arrows visited upon you if you do not come up with 25 letters after your name, so would you be so kind as to legitimize yourself.

Mr Hayday: Sure. I am the founding executive director of the Ontario Prevention Clearinghouse, the directeur général du Centre ontarien d'information en prévention. I am the chair of the community subgroup of the Better Beginnings, Better Futures model and a member of the technical advisory group for that model. I am the chair of the Ontario social assistance reform committee network working to identify systemic solutions for some of the problems associated with social assistance reform in the province of Ontario. Prior to my work in those areas I worked as the director of prevention services for a children's mental health service, as the director of a school community consultation service for a children's mental health service and as the director of parent education for a children's health service, all in the same agency. I am also an ex officio outside-of-government representative on the prevention policy steering committee for the Ministry of Community and Social Services.

Ms Haeck: Excellent. I think you bring a wealth of knowledge to this committee. Not only have you put it forward in a very articulate fashion, but you obviously have a great deal of experience out there in the community which you have really brought forward very well today. Thank you very much for your presentation.

The Chair: We have time for one final question from Mr Hope, very briefly.

Mr Hope: Yes, it will be very brief. It is good that you brought up Better Beginnings, Better Futures. I am glad to see you brought that up. You also indicated about the legislation that we would have to do in order to make changes and you say there is no need, and I guess I have to agree with you because we seem to have already been doing a labelling of people.

In our own meetings here today we are labelling individuals of welfare who are going to potentially become killers or rapists or whatever, and I do not totally believe in that philosophy. But I think what this government has to do in the upcoming future of its mandate is to make sure that, number one, we look at social programs and helping families get out of that environment, with either housing or job development. I think that is really where the focus of this is coming from, because I believe that the service providers who are there do not want to sit there waiting until everybody starts flowing in. I think we have to address it, and addressing it at the beginning is where we have to start.

I really believe that the philosophy of our government—hopefully in the mandate that is put forward by us, we will be able to take away from the waiting lists. As you deal with the waiting lists, we know there are two issues, prevention and dealing with the problems that are faced by the people of Ontario, and also to deal with the current

issue that we have to address, the waiting list that is out there.

I am glad to see you brought up the legislative aspect. There are other areas of legislation that we have to address. I think that is what this committee has to look at, where the potential or where the people are who are coming from and into the program. We have to really concentrate our efforts on that and I want to thank you for bringing that up.

The Vice-Chair: I am afraid we have run out of time. I would like to thank you for coming before us. We will now adjourn for 10 minutes until 1045, until we are able to put together the slide presentation which our next presenter is going to be making.

The committee recessed at 1035.

1045

HOSPITAL FOR SICK CHILDREN

The Vice-Chair: Our next presentation is from the Hospital for Sick Children, Dr Susan Bradley. I would like to point out that we have technical difficulties with the slide presentation that was supposed to take place, so we will put that to the side and we have a hard copy of your presentation. I think that will have to do. I apologize for that.

Dr Bradley: No problem.

The Vice-Chair: Please start your presentation.

Dr Bradley: Thank you. I appreciate being asked to come to address you. I would like to tell you that I have another hat and I think it is not just as psychiatrist-in-chief at Sick Kids that I have been invited to come here, but as head of the division of child psychiatry at the University of Toronto.

I think, in addition, I should simply tell you that I have been actively involved in a number of other groups oriented towards promoting and developing children's mental health services in Ontario, and these include the Sparrow Lake Alliance. I have been a member of the child welfare committee at the Ontario Medical Association for a number of years and am presently chairing the infant mental health promotion project for Metropolitan Toronto.

All of these activities tend to have a rather similar focus and some of what I am going to present to you is coming from that perspective. What I have chosen to do is to address the five topic areas which were part of your mandate. These may appear to have a certain redundancy, and I will try to limit that as we go along.

Under availability, I do not think I have to stress the fact that there are fairly significant limitations which have been pointed out quite clearly in the Ontario Child Health Study. The data indicating that there are roughly 18% of children with a diagnosable mental disorder and yet less than one sixth of those are actually receiving any form of treatment have caused us all to do some serious rethinking about whether or not we will ever meet the need with the present service system. Obviously, asking us to address some alternative type of service delivery system gets us clearly into issues of prevention and early intervention, but that is not the only avenue.

What I have chosen to do is to stress certain areas where I am aware that there are distinct resource gaps. I have chosen to do that in the three broad categories of age, diagnostic group and resources. There are two groups that stand out from an age perspective, one of which is infants, who have really not been recognized as having mental health problems until relatively recently.

I think those of us who have been working with families for a number of years are very much aware of the importance of early development and of infancy to the ultimate development of healthy individuals. At present, within our system there is no clear system of responsibility for infant services. They are spread broadly across at least three ministries.

Transitional-aged youth are again a group for whom there is no very well organized system of delivery of services. They fall neatly between the cracks. They do not fit neatly into the child and adolescent spectrum of services, nor do they fit very well into the adult spectrum of services. Constantly we are confronted with the fact that services, for example, for adolescents in crisis stop at the 18th birthday at Sick Children's Hospital, which is presently the only 24-hour emergency service available in Metro Toronto.

Most adolescents who are 18, who require crisis intervention services, are coming because of problems to do with their families. Those adolescents, by necessity, end up going to an adult facility, which does not really deal with families very adequately, so they end up having to get service from a system that is not well designed to meet their needs. This problem has been recognized in a number of reports, and I will not go on at length about that.

The diagnostic groups for which I am quite aware of deficiencies include the older conduct disorder group and particularly the young offenders, and the new Strategic Directions report is picking this up as a clear need, as has the Colin Maloney report. In addition, though, we are very much lacking programs for substance abusing and street youth. We have failed to deal with this issue effectively at all, and the university community is as lacking in this regard as is the broader medical community.

We are very much aware of the needs of sexually abused children and their families, but we have not succeeded in developing treatment programs that really meet those needs. There is a knowledge gap here. People who are writing in this area about children who have been traumatized will recommend that every single traumatized child should have individual psychotherapy.

Now that we know what the incidence of sexual abuse is in our society, and depending on what kind of abuse you are talking about, we are talking probably 10% of children at least. It is quite impossible to imagine providing individual psychotherapy for that number of kids. The issue becomes, are there other ways of intervening that really do address the needs of those children who have been abused and are as effective? We do not have the answers for that, but clearly we have got to get the answers for that.

Eating disorder is another issue in which there is no organized program. The great irony is that there is a very well organized program for eating disorders in adults. We

all know that eating disorders begin in children; they do not start in the adult years. Yet efforts to develop eating disorder programs have met with very little positive response. I will get into some of the reasons why I think we are not getting anywhere in developing some of these programs when I talk about the lack of clear responsibility but those are the obvious deficits in terms of diagnostic groups.

If we look more broadly at issues of resources, we are quite aware of the fact that we do not have enough long-term residential programs for seriously ill adolescents. We have closed institutions and agencies like training schools, and in doing that we did not open up an alternative system of care. Many of the youngsters who in many ways were being looked after in some of those facilities in fact have been left without adequate facilities. Many of the children in need of long-term residential programs are going out of province, and this is causing a very significant drain on our resources, which should not be going out of province. I should be diverted into development of those programs here within Ontario.

There are clearly some problems with the legislation for the over-16-year-olds, and I do believe that has got to be addressed. However, assuming that can be fixed, we are left with the need for more resources in that area.

In addition to actual treatment-type programs for the chronically mentally ill, we need group homes with adequate structure and psychiatric backup. One of the difficulties is that there have been funds put into the system to develop group homes, but if they are not adequately backed up from a proper mental health point of view, these kids are not being adequately looked after.

A recent study looking at the severity of disorder in the group of children at Kinark Child and Family Services was very impressive to me because these are very seriously disturbed kids. These are not simply kids in need of housing or resourcing. These are kids with major mental disorders and they are being looked after in a system that is not very well resourced. I think that is so throughout the system. If we are going to put these kids in these resources, we have got to provide ways of providing adequate consultative backup.

We are working in the area of prevention, and I think we all acknowledge the real importance of investing more of our energies in that area. I think we have got to work out ways of providing support to physicians, to schools, to programs for infant visiting and particularly in the area of parenting. This is an area which we have put very little resources into. When you consider the amount of effort that goes into educating kids in other areas, we provide very little hands-on teaching experience in the area of parenting, and yet everybody emerges and becomes a parent. We have very little real teaching or training in that area.

With respect to accessibility, I think it is quite clear that the groups which are most affected in this regard are the ethnically diverse and the low social class groups. They cannot access the system as well as somebody who has got the bucks to pay for private psychiatric treatment. That is

an issue that will go on until we develop a better spectrum of services.

It is clear also that many children get lost because of lack of co-ordination between settings. This is particularly acute in the more seriously disturbed where they require a spectrum of services or transfer from one service system to another, and in that process we know that children get lost.

The adequacy issue is somewhat redundant because I think I have already touched that talking about availability. One of the things, though, that does need to be highlighted is the need to involve the academic community to develop treatment programs and to evaluate those. As I have indicated earlier, in issues like sexual abuse we do not have the knowledge base to tell us what is the most cost-efficient way to intervene in these disorders. We are using models of intervention which have not been well tested and the university has the capacity to do that. There has been very little collaboration between government and the university and that creates two separate systems which go their own way. I do not think that that is a good use of our resources.

With respect to quality, we clearly have some excellent programs in the province, and we have some very poor programs. A lot of it has to do with resources and consultative backup as well as access to training.

I think that one of the most critical issues is the funding issue and I see it as the fact that children's mental health is not seen to be a priority. I think until we can get it on the table as a priority, until people can become convinced that the only way that we are going to have a healthy society is to have healthy children, this is not going to become an issue that people really get invested in.

I think that we see this over and over again in a situation like a large hospital such as Sick Kids, where psychosocial resources are consistently less well funded than physical health resources. It happens in the community. You can get access to a doctor if you have got a sore throat, but you cannot always get access to a doctor or support if you have got trouble with your kids. Those are the kinds of things that I think we have to get into some balance. Sore throats go away without much treatment. Trouble parenting your kids does not go away.

Under needs, I can only stress how important I think it is that children must become a high priority and that children's mental health has to be seen as absolutely critical to the general health of our society.

We need a more clear definition of ministerial responsibility for children's mental health. This issue of Comsoc being the leading ministry has helped in many ways, but what it has done is create almost impossible barriers between those agencies which are more closely allied with the Ministry of Health and those which are allied with Comsoc in that if you attempt to create appropriate and logical systems of care, you have to have a gradation between the back end, which tends to be the psychiatric or backup end, and the front end, which is in the community. When you get two totally separate funding systems, one of which is very reluctant to give to the other, you cannot create that continuum of care. This has happened and been very perplexing for us in the area of things like eating disorders where we have tried to develop programs and cannot get

the co-ordinated support to develop these kinds of initiatives.

I think that there have been lots of ideas floated around about what is the best way to go about it. There are many good ideas in the new Children First document, Colin Maloney's group. What is absolutely critical, though, is that somebody take responsibility for the whole spectrum of services, and that includes right from the very front end of schools and physicians to the backup end of treatment resources for the most seriously disturbed. We need to have a way of pulling those groups together.

It is critical that there be a planning process put in place to examine implementation of early intervention programs. It is fine to talk about it, but when this is left to each local community to develop on its own initiative, it does not work very well, and I am very leery about simply handing over responsibility along with funding to local communities unless there is clear direction from some central ministry to set up certain kinds of structures that are considered absolutely critical.

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I have recently come from a consultation experience in Chile and what impressed me—I went down there as the expert—is that they have a system of care and they are in the midst of developing a mental health program for all of Chile and they obviously have given it high priority. They see that it has to be centralized. They are giving recognition to the needs that are different locally, but they have a central thrust. I think we cannot lose the concept of a central thrust and the notion of going to local committees. We have got to work out both ends of that.

We have to look at alternative systems. There has been a lot of discussion about school-based programs and physician support programs, and probably we need a mixture of all of these. We need expansion of programs and I have identified some of the areas which clearly come to my mind. I can only emphasize the importance of involving the academic community, in both the planning and the evaluation of any of these initiatives.

We need research. There are many things that we know about the initiation and development of children's mental health problems. We need more treatment evaluation. At times when we are faced with constraints, with economic constraints, we have got to find the best ways of using our money, and that means evaluation of intervention.

We do need to know more about factors which protect children and these include work in the areas of attachment which are already developing. Social and peer variables have become very important in terms of understanding how children deal with issues as they mature. There is some interesting new work looking at a concept which is sense of coherence. There are factors which make people able to cope with various adversities and we need to understand what those are more coherently. There is also some developing interest now in affect regulation as important overall in development of psychopathology. These are things that we are beginning to understand in terms of genetic and other mechanisms which are important. But we have got to work together; that is the bottom line.

The Vice-Chair: The time for questions is very limited. I have Mr Hope and then Mrs McLeod.

Mr Hope: Thank you for your presentation. I like the way you have presented it to us. It is in point form and it leaves us room to jot notes down, which is kind of nice.

First of all, I just wanted to touch base on the resource, and you are talking about the group homes, with the adequate structure of group homes now currently in place. By the way, I may be misinterpreting what you were saying. You were saying that we should keep the flow of the institutionalized setting and develop that institutionalized setting into more training practices as far as getting out into the communities to develop a—

Dr Bradley: We have got to figure out ways of linking up the major institutions like the universities and the teaching hospitals with the community. That is what is lacking at the moment. We have got to figure out a logical system of care which involves the people at the back end who can provide consultation and training to the people at the front end in the community who are actually delivering the service. That has not worked very well, because of the difficulty with the reporting responsibilities, in part. Most of the psychiatric and hospital-related community is reporting to the Ministry of Health. Most of the children's mental health community is reporting to Comsoc. They have not worked out the integration between those two groups.

Within the Ministry of Health, community mental health is not responsible for people who are under 16. It means that if you are trying to develop a logical system of care which involves the institutions at one end and the community at the other and you want to bring them all together, you have to work with several different groups within the ministry who do not talk to each other and do not work together. That means you cannot do it. Practically, that is what it means.

Mrs McLeod: I knew it was going to be tremendously frustrating, with each of the people coming to our committee, that we would have such a short time to learn so much from what you have to offer. So of a dozen question areas, I am going to focus on one. The Maloney report, as you know, looks towards a more integrated, more co-ordinated system, which obviously you would concur with, based on your remarks. I was concerned, in reading that report, that I very much like the school as a hub focus, but I am not sure that it does not neglect a little bit support for physicians, which you have identified, and perhaps the way in which complex treatment needs can be met.

I would like to focus on your background in education. I worry that in anything we have tried to do there tends to be an either/or type of approach in where the priorities should be, when in fact you just cannot afford an either/or approach for children's mental health services. Do you feel, in the university setting, whether it is faculties of education or family practice training, psychiatry training, psychology or social work training, that there tends to be an either/or focus, that it is one or the other, that one gets a priority? Does there need to be more integration of orien-

tation at that level for us to be successful at the community level?

Dr Bradley: I think there is not, has not been at least—I go back to my own experience in being trained and I think it has not changed dramatically—a really clear understanding of the importance of children's mental health to ultimate outcomes. People are distressed about abused children and children who may have drug and alcohol problems or children who are being neglected. Issues like that are self-evident. But I do not think that at the broader level people understand how important it is for children to have stable, consistent relationships over time, how important it is that their needs get met in a variety of different ways. I think that kind of education has to become a part of what we teach children in public school, in high school, in all of our training programs, whether it be for physicians or social workers or anybody. I think there has to be more emphasis on how important children's mental health is and what the dimensions are and what you as an individual can do in your own professional practice to be alert to that.

Very few family practitioners are given real training in child development or in parenting problems or issues like those, and they see them all of the time. The ones who are particularly interested will seek out some more training, but the bulk of them feel frustrated, hope that they can find some resource in the community but oft-times do not do that. The ones who are tuned in to these issues are very aware that we have not addressed the issue because we have not addressed their need to be skilled in that area, in addition to which oftentimes some of them need things beyond what they could provide in their own practice.

There are lots of things. We could do a great deal more in terms of early intervention. Lots of general practitioners and paediatricians pick up families at risk. They can tell in that first year that a mother is having difficulty. Yet, oftentimes they do not know what to do about it. The resources to turn to are not obvious. There are very few early intervention programs available unless you are so disturbed or distressed that you really need to go to the children's aid society or to the food bank or to something or other like that.

But for somebody who is really just having trouble parenting, where do you go? Those are the people who end up ultimately going into the system later on and costing us an awful lot of money.

The Vice-Chair: I would like to apologize. We are very pressed for time. We do have to move on. I would like to thank you for making your presentation. I hope you can understand and appreciate that we are very pressed for time, so we are going to move on. Thank you.

JEANNE SAUVÉ CENTRE

The Vice-Chair: Our next presentation is from the Jeanne Sauvé Centre, Kapuskasing, Yves Barbeau, executive director. Welcome to the committee.

Mr Barbeau: Thank you. It is certainly a pleasure to be here today.

The Vice-Chair: As I have indicated to other presenters, you have the half-hour. We will stick to that strict limit of your time there. Please commence.

Mr Barbeau: Okay. I understood that my presentation today would be bringing to you a perspective of a northern children's mental health centre with a specific component of francophones. My presentation will focus on some demographics about our area and then some specific issues that our centre is facing. Probably we are not the only ones facing those issues, but they are only applying to us as of now.

I think you all received the little document in front of you.

Demographics: In terms of being open since 1980, we changed our name in 1987 because development, with the new legislation, was reflecting on the services we were providing. Child and Youth Development Centre was our first name. The Child and Family Services Act, in terms of development services, did not quite reflect that.

We have a \$1.4-million budget with about 30 staff. We cover approximately 225 kilometres from east to west, no road north and south in our place—65% francophone, about 30% anglophone and 5% native, and this is across the catchment area. In some places it is 100% francophone, in some others it is 95%. The basic concentration of anglophones is in Kapuskasing, which is about 12,000 population.

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We offer six community-based programs and I mean by that family intervention, psychological assessment, family violence program, home intervention and one eight-bed residential francophone facility for 10- to 14-year-old children with emotional problems.

Of the specific issues we are facing in terms of availability and accessibility of services, I think I can start with continuum of services. I think it has been highlighted in the Investing in Children paper, the northern interaction paper as well. I want to talk about a whole range, and in our place we are offering six programs. Obviously we are missing quite a bit in that spectrum, and where it is going to go in the future I am not quite too sure, but being the only game in town, with one children's aid society, I think, whether we share the spectrum or we create another one for us, where it is only not there. We have a limited number of staff as well who are helping all those programs and it is a live-in staff in the community base. We offer, obviously, no prevention services at this point in time. We do not have time to do that.

We have three points of services as well across those 200 kilometres. Kapuskasing is located in the middle and you have to travel about an hour east and west where there is a satellite office. Four of those five community programs have one or two staff in them, which means, like a family violence program for example, there is only one staff member, who has to cover 225 kilometres and be bilingual as well. You have to provide services in at least two languages. We are not providing any native services at this point. Sometimes you are looking at the kind of population you have to serve. For a battered women's

group, for example, you would be offering in three communities in two languages. You are already starting with six groups and you are alone in that program. It makes it quite a bit difficult.

In terms of waiting lists, I think our average length is about six to seven months at this point in time, 43 cases, and some of them have been on the waiting list for 14 months. Obviously, those ones are not the severe homicidal or suicidal cases.

In terms of adequacy and quality of service, "recruitment" and "retention" are big words in the north. In our place especially there has been staff turnover since 1980. There was not a year without losing staff, which was basically between 15% and 25%. This year we are about 20%. So out of 32 staff with contracts, we guess at between six and eight people every year.

All our clinical staff have less than four years of experience and once they get to be more experienced, they usually go down south or back to Quebec. The impact of this is, some communities would not have any services for six months for one program. For example, we have just been responding on a crisis basis and sending one of the staff just to look at the suicidal case and then come back to Kapuskasing and travel. Some clients would be seeing three clinicians in one year. That is a fact of life in our place.

I think the impact of Bill 8, as well, on bilingual staff—I think it has been a great initiative. In Kapuskasing, however, it plays a bit the other way for us because now some agencies in the north will be recruiting some bilingual staff and I am pretty sure someone would rather be in North Bay than in Kapuskasing, which might not have been there before. I think in our place the problem is not recruiting francophones, I think it is anglophones. We do not have any anglophones at this point in time, out of 30 staff. So it is all basically bilingual. It is francophones who are offering the services. With all the shortage of staff everywhere in the province, an MSW anglophone would not be in Kapuskasing, I am pretty sure. He would find a job even here in Toronto.

Most of our staff are recruited in Quebec because of the masters level. Ottawa university was the last university to provide an MA in psychology from a francophone point of view. Now that Ottawa has closed that program, there is no place we can really recruit except there. And obviously those people are out from university, come to our place, get some experience, go back there. It is a cycle that perpetuates itself all the time.

I think salaries did not help us too much to recruit either. Like in 1988, 1989, they can just be called the master level. After five years of experience you are being paid \$30,000 a year, starting at \$27,000. That was two years ago. Add even 10%, it does not make much. So we have to upgrade them. I do not think we have much choice. We did not quite receive financial support on a permanent basis, but I think we are somewhat looking forward to it.

In terms of understaffed programs, I think there are two that strike us in the north. One is the day treatment, this kind of venture with the Ministry of Education and MCSS. Since I have been there, we have never had full-

time child care workers in the classroom as it appears to be our mandate to do. The board of education would put a teacher in the classroom but with no staff to help him. So we are just providing consultation, whether an hour a week to them or a day a week to each teacher, depending.

I think a decision has to be made at some point in time if we are going to keep those classes open or we are just going to close them. We are not too sure if it is our end to take a serious look at it or to let the ministry say: "Is this venture working or not? Are we going to close the section 27?"

At the residence we do still have one night staff person per shift. I think since the tragedy that happened a year ago, there was a decision to staff all the residences with two night staff people, at least. I guess the bus stopped before reaching Kapuskasing, because probably the secure and open custody centres got the first shot at it, and then Kapuskasing. We are probably not the only one, but obviously we are the one at this point that does not have two night staff people.

In terms of professional development, being in Kapuskasing as well is a disadvantage. Travel costs: we do have some budget. Let's say people with \$1,000 per staff a year is great. Well, it costs us \$700 in travel to come to Toronto. It does not leave much to do other things. We use senior consultants on a surplus basis most of the time, and when the surplus is gone, so is the consultant.

In terms of funding, for us some issues are the ministry initiatives versus priorities of service plan. In the last year we had three new initiatives: northern integrated services was one; family violence was one; preparation for independence was another one. It was great to have those programs but they were not at the time a priority of the service plan because the expansion of some of the existing programs would be our first priority probably, because we do have limited staff in each of them. I am not sure how this is going to be negotiated in the future. Maybe it is a good thing for Toronto to get some of those initiatives, but in Kapuskasing I think we need to just consolidate and build on the existing programs we already have.

Are there funds available for new expansion of programs? I think it is always a question we have; probably everybody has that question. I think it would be at some point reassuring for our communities to know what we are going to do in the future and if there any funds, because with all the salaries that have been upgraded and the new rent we are paying, we are more likely going into reduction of services if we do not get funds to back us up. There is some impact of new legislation. I guess everybody is living through it, whether you be in the south or the north; pay equity and GST and Occupational Health and Safety Act and even Bill 8 to some extent.

In conclusion, just a few words of, not my wisdom, but it has been said before that it is doubtful that each of us individually will be able to meet the challenges of the future, as it is unrealistic to believe that injecting more funds into the system will solve all the problems. Even in Kapuskasing, we are aware that that principle of trust, partnership, collaboration, co-operation which has been

referred to for a long time must now be embraced by all the players if the system wants to succeed.

That is something we have been working on in Kapuskasing as well, having shared board meetings with the children's aid societies, signing protocols with schools and with all the players in town, because that is probably the only way we can offer service, if we can get them; we might as well join if we can.

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The Vice-Chair: I have Ms Haeck on the list first; Mrs Witmer, Mr Beer and then Mr White.

Ms Haeck: Mr Barbeau, it is interesting to get your perspective in comparison with some of the others we have received today. You indicate that at this point you are not providing any native services. Have you looked at hiring any native staff to possibly address this in the future?

Mr Barbeau: No.

Ms Haeck: Do you encounter any situations where you have a unilingual native person, where the language of that person does not happen to be English or French?

Mr Barbeau: It would make some sense to think along those lines. I think there are some new developments in the north with some other organization being created to service the native people; that is why we are not getting into that line. A new organization was just set this year to look at those reserves and native people, so they are already making some changes. The children's aid society, for example, was the one service in the native reserve in our place, with a prevention and protection worker. Now, this new organization is taking over all the prevention workers in the north.

Ms Haeck: What is the name of that organization?

Mr Barbeau: Kunumanimano.

Ms Haeck: That is fine. You can pass me a note and spell it for me.

Mr Barbeau: Maybe Mr Beer has heard about that one before.

Mrs Witmer: I would like to thank you for your presentation. It is obvious that you experience some frustration; your situation is certainly unique as compared with some of the others in this province. You mention that it is unrealistic to expect that the injection of more funds is going to solve the problem, and then you talk about partnership and co-operation. I wonder if you could expand. What type of service model would you see as contributing to some of the problems you face in the area you serve?

Mr Barbeau: I think the idea of integration has been extensively discussed in the north with the northern directions paper for northern children. I think integration means different things to different people. I do not see it as amalgamating different organizations under one board and one administration with different streams within that organization. I see it as all the players coming to the same table, in the same way as the integrated service for northern children sharing the service delivery for each child. Each service provides what it does best to the child but in a case management manner instead of just transferring the case

from left to right. Whether this applies to the community or to the ministry in terms of integration—is the ministry going to put all the funds for children's services under one ministry and then branch out to fund all the community agencies? I am not sure if it is the best solution at your level, but at our level I think it is just sitting with all the players; like Education and MCSS, for example, with section 27. I think it has to be discussed at the upper level and at the lower level.

Mrs Witmer: Do I hear you saying there would be some value in establishing at the local level some sort of a children's advisory committee?

Mr Barbeau: I have heard that concept before. Depending on which kind of mandate and power as well, whether it be financial or just recommending powers. It might be a good idea. I would not mind that.

Mr Beer: One of the things I always found interesting is that in the north—I suppose, really, out of necessity—you have probably moved in many ways a lot further down the road of working together because of the limited resources; people really have to make use of each other in terms of services. In the south we might learn from that.

Because we have a short period of time and because you are working in large part with the francophone population, I want to focus my question on Bill 8 and the development of French-language children's mental health services in the province. Are there perhaps two or three things you might want to recommend that we should be urging the government to focus on particularly in meeting the needs of francophone children? Are there particular things, as you have seen Bill 8 come in, as you try to develop your programs in the north, where there could be help? You mentioned, for example, the problem that the University of Ottawa now no longer has an MA program. One time when I was up in Kapuskasing you mentioned that you go to Laval each year to recruit. What are perhaps two or three things we are going to have to really look at if we are to ensure that the francophone population is properly served under Bill 8?

Mr Barbeau: It has to be in connection with the Ministry of Education as well in terms of providing graduate programs. It does not have to be in psychology; it can be in social work, it can be for child care workers, for example, some impact for the francophone population, which is not strictly based in Kapuskasing. There are some francophones in Timmins, in Kirkland Lake and across the north basically. There needs to be a link between the two for upgrading for education. I think some of the board members wish there was a Bill 8.5 to ensure anglophone services in Kap, because we just went through it. It would be any other easy day-to-day stuff; it would not have a big impact. It is kind of hard to say what kind of recommendations we can make other than to link with education, because it was not a big problem for us.

The Vice-Chair: I would like to thank you for making your presentation, for coming such a long way. I am sure it was enlightening for all the members of the committee. It will add to our base of knowledge we are acquiring for our

research paper to be put together, tomorrow, actually, as we discuss this.

Mr Barbeau: It was my pleasure. I guess I will be flying back to Kapuskasing. There is not enough snow here to go back by dogsled.

SIMCOE COUNTY CHILDREN'S AID SOCIETY

The Vice-Chair: We will be moving right along to our next presentation, the Collingwood branch of the Simcoe County Children's Aid Society. Mike O'Brien is the director and Dave Myers is the director of placement services. I call them to make their presentation at this time. Welcome to the committee. You have half an hour. You are entitled to divide that time as you see fit. If you would like questions at the end of that time, allow yourselves some time for questions by members of the committee.

Mr O'Brien: My name is Mike O'Brien. I am a branch director with the Simcoe County Children's Aid Society. I will speak for part of the time and then Dave will speak as well. I will deal with the non-residential aspect of children's mental health and Dave will deal with some of the residential questions that have to do with children's mental health.

In the package that has been circulated to you, there is some information about a program I supervise called South Georgian Bay Child and Youth Services. It is an outpatient children's mental health program operated by the Simcoe County Children's Aid Society. I will spend a bit of time talking about that. There is also a paper entitled *A Role for Children's Mental Health in Child Welfare*. We will spend some time talking about that, the premise being that children's mental health is a very broad area and that the child welfare system is part and parcel of the package when you are looking at children's mental health.

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First, with respect to South Georgian Bay Child and Youth Services, as I said, it is a child and family counselling service operated by the Simcoe County Children's Aid Society, which makes it very unique. That is very unusual. Very few children's aid societies in the province operate a child and family counselling service. One does not have to be a child welfare client to have access to this service.

I would like to talk to you about something you will probably have heard and will continue to hear about, but which I think is probably important to know about, that is, the whole question of availability of services in children's mental health. In Collingwood we have a service that serves Collingwood and area, which is about 40,000 people. We have two social workers who are available to provide that service. What that means is that people will often wait six months before they are able to see a social worker. That means that children who are in need of treatment, whether they have been sexually abused or whether they are suicidal, will often wait for six months when they have these very serious problems.

That is not unusual just to Collingwood. We have branch offices across the county and I can report that that is not unusual at all. In fact, I know of one service in the Barrie area where families and children will wait nine months for any type of counselling service. There have

been, of course, numerous attempts to obtain extra funding for more staff over the last three years, but we have not met with any success in obtaining extra funding so the problem remains very serious.

As I said, the other area I wanted to talk with you about was the role of children's mental health in child welfare. The ability of the child welfare system to address the mental health needs of children is being seriously eroded and is being further eroded. In the child welfare system we see our mandate not only to protect children but once we ensure the immediate safety of a child to do something about the family situation so the family problems can improve to a point where the child will be safe. Unfortunately, more and more we are becoming social cops and not able to provide the vital counselling services that families require in order to remedy some of the problems.

The legislation gives us a mandate to provide guidance and counselling to our clients. There is a flexible services section of the Child and Family Services Act which talks about the possibility of providing funding from different areas to meet the needs of children, so we certainly feel we have the mandate to provide children's mental health services but simply do not have the funding to be able to do it.

At South Georgian Bay Child and Youth Services, we feel that one thing we have been able to do which a lot of child and family counselling services are not able to do is be very helpful to socioeconomically disadvantaged clients. It is important when you are looking at children's mental health that you look not so much at the traditional boundaries of who ought to serve whom, but at what types of services are best suited to meet the needs of the children we are talking about. In some cases the child welfare system is in a better position to meet the needs of children in families than some of the traditional child and family counselling services that are available. The reason for that and the experience I have had over the last three years with South Georgian Bay Child and Youth Services is that because we are operating in a children's aid society we have some unique abilities to work with socioeconomically disadvantaged families.

As you probably know, for the most part children's aid societies do deal with low-income families and develop a certain expertise in dealing with people from low-income families. Because of that, South Georgian Bay Child and Youth Services has been a kind of unique model in that in the 12 or so years I have been in the child welfare system I have never felt more positive about our ability to provide treatment services than I have over the last three years, because of the fact that within our children's aid society we can offer a treatment program to low-income families.

The traditional approach taken is that a child welfare agency does an investigation of some particular problem and then the agency refers the family on for services elsewhere; the child welfare agency cannot provide the treatment services to the family. In my experience, where we have this treatment service available within our agency, where we have already engaged a family and developed a relationship with them within the children's aid society, it is much easier for them to make use of a treatment service

offered within the agency as opposed to going to some brand-new agency. Our child welfare clients feel very threatened by that. It takes a long time to develop a relationship with them. They are very resistant to making use of counselling services; that is why when one attempts to refer them to other agencies very often that is not successful. So, as I have said, I am very pleased by the fact that we have been able to offer a treatment service our clients can make use of. That does not usually happen.

What I would encourage is that when we look at different models for providing children's mental health services we continue to look at all sorts of possibilities and that we not ignore the very vital role that child welfare agencies should play in providing treatment to children with mental health problems. That concludes the comments I wanted to make.

Mr Myers: I want to give you some quick perspective on Simcoe county and the lack of services we have. We have no children or adolescent psychiatric units in any of the hospitals throughout the county. Basically, we have two child psychiatrists in Barrie. Naturally, they have extensive waiting lists and really cannot provide immediate service to children or families; they have an ongoing case load, obviously. What this means is that in crisis situations for an adolescent we might be able to secure treatment at Whitby or Youthdale or that kind of service outside our area, but within our community basically all we have are psychiatric wards for adults, or perhaps in certain situations a general practitioner will admit a young child to a paediatric ward, so obviously we are have very much of a make-do situation in terms of just general psychiatric care to children and adolescents.

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I think we who live in the county and have been there for some time, who are seeing the growth of Barrie and the southern part of the county, really continue to wonder how long this county can go on not having some sort of basic psychiatric service, at least in some part of the county. The fact that we are shipping kids out, as I say, to Whitby Psychiatric Hospital, Youthdale Psychiatric Crisis Service, etc, we just think is not adequate.

We do have some facilities that are funded by the Comsoc for adolescents and young children, so we cannot say we do not have services available for kids with behavioural problems or emotional disturbance. We have Blue Hills Farm, Robert Thompson Youth and Family Centre and Kinark. We have had some services available so I do not think we can say that it has been doom and gloom in that sense.

Of course you all are probably aware of the Kinark tragedy last year, in Midland, in our county. Naturally we found that Kinark has been very restrictive in its admissions since that. We have traditionally, as an agency, looked to Kinark to provide treatment to young children; this would be eight and up. Over the last number of years they have preferred to work with that younger age group but since this tragedy, naturally they are very cautious about what kind of child they will admit.

We recently had the unfortunate experience of realizing that they had a bed available for a nine-year-old boy whom they agreed was appropriate for their program due to his emotional problems and his aggressive behaviour and so on, but their staff are so frightened these days that they are actually now—I hope I am not treading on Kinark's toes, because I am assuming they might speak to you at some point today also—looking at the extended family, wanting to know who in that family might represent a risk to their treatment staff. In this case they discovered a common law partner who is presently in jail and they felt he potentially was a risk, so they turned the child down on the basis that this extended family member poses a risk, so as an agency we had to provide a specialized foster home for that boy.

Obviously, as I say, I do not want to be overly critical of Kinark because of the tragedy it has been through, but I would like to highlight to you that I think that kind of situation, I guess, represents a number of problems. We need more resources. We need more funding, obviously. Hopefully, in the future staff in that kind of situation are going to feel they can provide services to a nine-year-old boy who could otherwise be in deep trouble.

I want to highlight a couple of other areas just briefly. We are seeing quite a gap between what we would call crisis service and long-term treatment. As I mentioned, if a child is suicidal or homicidal, there is probably not a great deal of difficulty getting him admitted to Whitby or Youthdale, but that treatment or that crisis service is only going to last three weeks or a month, maximum, and then they are knocking on our door, saying, "Where's this child going to go next?"

If we are lucky, we might find a spot in a facility like Blue Hills Farm or Thompson centre in our own county, but if they have no beds we are really hard pressed. We have some group homes operating in the county—some have closed—but there really are not enough long-term beds that would have adequate staffing and adequate consultation and backup. I think the fact that we just do not have a basic psychiatric service in the county also really impacts on these other services that are operating, because if they take a child who is suicidal or overly aggressive or whatever, if they do not have adequate backup and consultation, they are very hard pressed to deal with these children.

There are the obvious sort of extraordinary situations. I remember about three years ago we had a boy who attacked someone with an axe, so therefore he met the criteria for secure treatment. We have a lawyer on staff and he was able to go through that court process and get that boy into Syl Apps Youth Centre for a period of secure treatment.

Again, I think it shows that we have this sort of all or nothing at all. At one end we have nothing. At the other end, if you meet this very rigid set of criteria, you might be able to get secure treatment through the court. But for this whole area in between we are really lacking in services.

Maybe you have questions. I think we need to try to highlight some of the areas that are in need in our county.

Mrs McLeod: Once again, it is hard to know exactly what area to focus on, but perhaps I will come back to the fact that this is a children's aid society with a difference,

rather than touching on the whole gamut you have just raised about the gap in service, which I know is true in so many parts of the province. The fact that you are a children's aid society with a difference is of interest, both in terms of why it happened—I gather that is related in large measure to the lack of service in a sense on the regional administration's part, that you were there as an agency and could perhaps step into an area of service delivery that other children's aid societies are not involved in. It would be interesting to look at the decisions about funding from global budgets and how that has been managed for you.

But perhaps if you deal specifically—there is a sense that we heard previously on the committee that there needs to be a clear separation of treatment services and children's aid society child welfare and protection, that the families because of the clout the children's aid society has legally to literally remove children from the homes, to take legal action against parents—that they are not in a good position to be able to provide the intervention and treatment and support. Do you feel that is a need from your experience? What I have gathered you are saying is that families not only accept it, but that it can be almost a preferable position. What happens then if you have to take the next steps and are they conscious that you can take legal action if they do not participate?

Mr O'Brien: I think you are quite right. I think that sort of an approach cannot always work, but the way we have our children's mental health service set up is such that we operate it as a distinct service and that if a client is making use of that service, that is their choice, whether or not they make use of that. They may be involved with the protective services of the children's aid society and be required to be involved, but the message that we give to them at South Georgian Bay is that this is your choice to be here and if the children's aid society says that you must be here, you may decide that you will follow that guidance, but we are not requiring you to be here.

In a lot of ways it is operated as a voluntary service. I think we have in some ways a two-tier system in this province in terms of children's mental health, that the middle class make use of the more traditional child and family counselling agencies and that the poor are dealt with by children's aid societies.

There are a number of reasons for that. I have mentioned one of them. I think there is a real sort of resistance and feeling threatened in making use of services. They are not people who reach out and who will make use of services perhaps quite as easily as the middle class. It is unfortunate because what we have with this two-tier system is that as children's aid societies become more and more social cops and do not have the manpower to provide counselling services to their clients, it means that with this two-tier system for the low-income people in our province, those children are not receiving the type of counselling services they need. That is one thing that I felt very good about with respect to this service. I think one third of the clients we service at South Georgian Bay would fall below the poverty line. We track goal achievements and 60% of them have made some really positive gains. I can assure

you that is unusual, from my experience in the child welfare system, to see that kind of progress.

Mr Myers: Can I make a brief comment? We have been a progressive agency and I think we have every confidence that if we had more dollars we could organize more service and deliver it. But I want to tell you quickly about one program we have which we feel has really worked wonders. We have a teaching homemaker program, and as Mike was talking about a two-tier system, these are primarily women—there could be men also, but they are women who go into homes and really offer a hands-on kind of service with child management, household management, budgeting and a whole variety of practical day-to-day events.

We could double our staff in that period, because once we have made that connection, as Mike said, maybe the lower class is not as organized or does not have the ability to get to a traditional counselling kind of service, but if you can deliver a service in the home where it has immediate impact on the children and the way that household functions, we could service many more of those families. Yet the paradox of it is that we are having to fight with Comsoc now to continue funding that program, because under the rules of the game with Comsoc, they are saying, "That is not technically a child protection service and you are a child protection agency." We are having to battle like hell to get those dollars and yet every day I think that ministry office would agree that we are delivering a very viable and valuable service.

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For every family that we can serve in that way, if we can prevent those children coming into care and make them a more functional family and those kids more successful at school, we could save a bundle of dollars, I know. But that is the dilemma. We are having to fight tooth and nail to get those basic dollars.

I think what we would argue is, why not enlarge the scope if you can prove a viable service? I mean, everything does not have to be a traditional counselling service. In fact, one might debate and say that this kind of service in a family is much more valuable than sending them off to see a psychiatrist or a social worker every two weeks, because it is artificial in a sense and does not really meet the needs. I think it is really a question of service delivery and can you offer a viable service.

Ms Haec: I welcome your report and I have also had the privilege of having some discussions with my local children's aid society and have met with members of the Niagara Children's Services Committee, which is really a volunteer organization giving umbrella service and allowing some co-ordination and discussion around children's services areas. But despite the fact that they meet regularly and do have some discussions about what is needed in the Niagara Peninsula regarding child care and children's mental health, all of the issues, it has come to my attention—which is something that you bring out as well and maybe you can come out to address how to correct the situation—that the children's mental health centres that do exist are not only restrictive but really deal with success

stories when they admit children. They do not deal with the youth.

I wanted to ask this question of Dr Bradley when she talked about transitional ages, what ages she was speaking to in the sense that we seem to be talking about, even in your situation, that Kinark is not talking about even allowing young adults into its programs, although that really would be part of its mandate. In our area it is extremely difficult to find placements for young adults, children 15 years and up. Do you see the same problem in your area and do you see any way of solving that particular problem?

Mr Myers: That is a complex problem, I would think. I think we face it also and part of the spirit of the act we are working under now was to move away from that idea that you send a lot of kids into group homes or put them into treatment, and then not have them do well and have them sort of bounce around and flounder around and eventually end up in the training schools. So we understand the spirit of the act, but there obviously are some very troubled kids out there who, if you give all these choices and liberties and then also arm them with a lawyer at family court, could successfully avoid being in placement of treatment.

Maybe the pendulum has to swing back a bit and maybe there needs to be a little bit more teeth at times in order to force a kid into a treatment situation. As it is now, if a kid says, "I am not doing it and I am not staying and I will run," it is very hard to compel him. Obviously it is a sensitive balance because we do not want to be in a situation where you are forcing kids and compelling them and locking them up. That is the other extreme, but maybe we have swung the pendulum too far in the sense of individual choice and liberty.

It is a sense of balance, but parents complain, "You're telling me I can't get my 15-year-old in treatment because, he says, 'No, I won't stay.'" That is the bottom line. We really cannot. Maybe we need to re-examine the legislation. I do not know. That is one area and obviously we need more resources too.

Mrs Witmer: You have pointed out to us again the problems we are experiencing on this problem, the lack of co-ordination, the fragmentation of services provided, and I would like to compliment you on your attempts to meet the void, the gaps in the service. I think you have done an excellent job.

I was particularly pleased to hear about two things that we were doing. We talk about the long waiting lists; we talk about the increased number of children who are requiring mental health treatment. I believe we do need to focus on prevention if we are going to reduce that list and I think you have indicated you are doing something that I am certainly supportive of.

I notice that you are doing something else as well. You mentioned the homemaker plan and you mentioned the parenting courses. Do you feel that there are at the present time in this province parents who lack parenting skills? Obviously you do, but what is the cause of this? Why has this happened? We have heard from Mr Morris this morning, for

ample, the reason for it happening in the native population, but what has happened to us?

Mr O'Brien: It is a very difficult question, but I would most certainly agree that lack of parenting skills is a serious problem. In fact, if you picked probably one of the five most serious problems that we would deal with at a children's aid society in terms of the difficulties the family has, lack of parenting skills is right up there in that top five. The ability to provide parenting education is extremely important in terms of prevention and to have the funds to be able to offer those types of courses.

As to the origins of the lack of parenting skills, I cannot really say why that would be the case. It certainly tends to reason that if parents themselves, and this is what we often see, have very limited parenting skills, they just do not prepare—they cannot possibly, they are just not quipped to prepare—their children for the types of life skills and problem-solving abilities that those children are going to need when they become parents. That is time and gain what we see, that the children are just not being quipped at home because of the lack of parenting skills that their own parents have. So it is continuous from one generation to the next.

Mrs Witmer: Are you encouraging these people to come forward and participate in the parenting programs, or what method are you using to bring them out to the parenting courses? I would think some of them would be quite reluctant to acknowledge the fact that they are unable to parent effectively.

Mr O'Brien: We have not had too much difficulty actually. We have been running parenting courses out of the Collingwood branch now for about a year and there is never any problem getting enough people to come to the courses.

Mrs Witmer: So people are looking for help then?

Mr O'Brien: Yes, very much so, and out of that, one thing we are doing is helping them establish self-help groups because, as you said, prevention is really an area that we have to move heavily into in this province, and I think self-help groups are one way of doing that. People learn that they can support each other and that they do not always have to resort to more and more services.

The Vice-Chair: Thank you very much. We have run out of time for this presentation. I apologize to those members who did not get their questions in, but we simply have to abide by these very stringent rules. Thank you for making your presentation.

Mr O'Brien: Thanks for your time. Most appreciated.

The Vice-Chair: On a point of order, Mr Malkowski?

Mr Malkowski: Yes, I would like to bring up a point of concern actually. The first thing, it seems to me when we look at the list of people for presentations, I am looking at the absence of mental health consumers. There does not appear to be anyone who will be making a presentation and it looks like a lack of consumer participation. I do have a concern that we are going to miss their perspective.

1200

The Vice-Chair: The only thing I could comment on that is that we referred the matter of scheduling to the subcommittee prior to our meetings being held and each of the caucuses was given an opportunity to put forward in the agenda with respect to those groups who made presentations to us. The various presenters could have included those groups. I would refer that to the subcommittee.

Mr Beer wants to raise a point.

Mr Beer: Yes. I think Mr Martin yesterday and then again today raised the question of those who come before the committee. I think we need to recognize that, apart from perhaps just a couple of these sorts of 12-hour committee hearings, this is really a very new mechanism in the Legislature. I think I share with others that sense that we have to look at how, once the issue is brought forward—and it is always brought forward by a particular party that says, "Look, we want to discuss that." They may well have thought through how they would like to see the question addressed and have some groups or individuals. I think we are going to need to fine-tune the process because there are some lacks.

Clearly in 12 hours, no matter how much we try to plan, we are never going to have everyone, but I would suggest that at the end of our two weeks there may be some observations around how this works that we want to provide to the House leaders. I suspect we may find similar sorts of issues that will arise at other committees which are doing this for the first time. Apart from the food bank issue, this is the first time that the social development committee has done these.

Perhaps we might then want to talk with our own caucus members and then at the end, in terms of the future process, try to have a system that will ensure that wherever possible we do not have some of the holes that may emerge.

The Vice-Chair: Mr White, I do not know if we want to get into a long debate about this, but I will entertain a few more comments.

Mr White: No. I think this is a very significant point that my colleagues bring out to Mr Beer's request. I think there are two points to that. One is that although we have only 12 hours, our report and recommendations will be significant. It is therefore incumbent upon us to mention that very significant lack in terms of these hearings. Essentially we heard from a great number of educators, some directors, service providers, psychiatrists, fine, outstanding, educated service providers, but none of the consumers.

It somewhat puts in question the committee's findings. I think it is incumbent upon us to note that in our report, but further that this particular and significant lack is also something which is a part of and endemic to the delivery system. There needs to be an effort, and perhaps that needs to be one of our recommendations, to enable groups to participate wholeheartedly from a grass-roots perspective and not simply from a professional perspective. That needs to be part of the information of our government.

The Vice-Chair: I am getting instructions from the clerk suggesting that those recommendations regarding procedure must be referred to a procedural affairs committee. It is not really appropriate to put that at the end of our report with respect to this subject. We might separate the two things and refer that to the appropriate place, whatever committee that is, and therefore proceed.

This is new, and as Mr Beer has pointed out, I think we all have to work through this process to find out what works best. I feel that we are in a hurry-up offence in the last minute of a football game.

I thank the members of the committee for their co-operation in trying to get through this, but we are restricted to the 12 hours and therefore we have to keep within those limits. That is something that is imposed upon us and we have a difficult time getting out of that.

Mrs Witmer, a last comment.

Mrs Witmer: I do not think it is appropriate that we engage in this debate at the present time. I think at the end we can. I just remind all concerned that, as has been pointed out, there was a subcommittee with representation from each party. In future, obviously, if individuals have concerns, they should be sharing them, in your case with Mr Owens, to make sure that the individuals and groups you feel should be recognized are placed on that agenda. I think what we try to do is give each person an opportunity to place an equal number there.

The Vice-Chair: Those concerns are duly noted. As I say, I think the suggestion has been made by the clerk that we put that forward to the appropriate place and try to make those recommendations count.

We are adjourned until 1:30 pm.

The committee recessed at 1205.

AFTERNOON SITTING

The committee resumed at 1330.

**MARY MCGILL COMMUNITY
MENTAL HEALTH CENTRE**

The Vice-Chair: We will call upon Mary Lou Moir, who is the co-ordinator of the Mary McGill Community Mental Health Centre in Alliston. Welcome to the committee. As I have been repeating this version of my gospel, we have a very strict time limit. You are entitled to half an hour, so you have the choice of dividing that up in whatever way you see fit. You can allow for questions at the end of your presentation if you desire to do so.

Ms Moir: Children's mental health: I am wondering how far Simcoe county has come as of January 1991 in terms of funding and services. On a scale of 0 to 5, I feel that we at the McGill centre are stalled at about 1.

I come today representing south Simcoe county as a service provider. I am the co-ordinator of the Mary McGill Community Mental Health Centre of Stevenson Memorial Hospital in Alliston. This is an adult mental health program funded by the Ministry of Health, community mental health branch. We also sponsor two youth programs; one is a life skills funded by the Ministry of Community and Social Services, and a youth employment centre which is funded by the Ministry of Education, as well as a child and family counselling intervention program. I am the director of these programs and speak to you today in my professional capacity.

South Simcoe county is situated just north of Toronto and is included in the central area of the Ministry of Community and Social Services administrative regions. My area office is in Barrie, 45 kilometres away. Up to 1 January 1991, Alliston was the centre of the southwest part of the county. It was at the hub of four townships and is bound to the east by Bradford. Recent amalgamation will change the structure of our region, but it is not going to change our catchment area. Stevenson Memorial Hospital is located in Alliston, as is the area's mental health services. It is a mixed rural and urban area, which has its distinct communities with individual needs. Growth in the 1980s has expanded the industrial base and thus increased urbanization. For example, Alliston has gone from a town of just under 4,000 in 1980 to its present population of 5,200. As Metropolitan Toronto has stretched northward, southwest Simcoe county is becoming more of a commuter community. That has brought with it young families requiring a lot of support and service. There are also other township restructurings that have occurred over the last decade. This has not changed our population base greatly, but it is an area to which families come because there is affordable housing.

How were our services developed in south Simcoe county? The Mary McGill Community Mental Health Centre was established in 1980 through the efforts of Mary McGill, a community member and health professional. She was aware of the lack of psychiatric services in Alliston and area. Until then, obtaining treatment in Barrie, Penetang, Toronto or Newmarket proved a hardship in

terms of distance in an area where surveys had indicated a higher than average rate of suicide, alcoholism and marital breakdown. As soon as our doors were open in January 1980, it became apparent that not only were services needed for adults but for children and families as well. We offered these services to the community, stretching our mandate from adult mental health, that is, to persons over the age of 18, to serve their families as well. In 1984, interim funding for a children's worker was granted, I believe from surplus funding from the Ministry of Community and Social Services. We borrowed a worker from another agency in Barrie on a part-time basis, and as soon as he arrived his case load was filled with complex, severely disturbed children and their families. He could only carry a percentage of the families in need, and so the adult program counsellors were still carrying a case load of families who had children under the age of 18. In 1988, full funding was approved, which gave us our present staffing quota.

South Simcoe county, as you are all aware from this morning's presentation, is also the location of Thompson Centre in Cookstown and Blue Hills farm in Everett. As residential treatment centres, these facilities have been located nearby but took most of their clientele from our area. They, too, were funded in 1988 for in-home counselling and treatment services, and they divided the area between their two programs at Highway 27 in Cookstown. Our service is a traditional office-based one in which clients come to our facility, and we serve the whole of southwest Simcoe county.

By the time our ongoing funding was approved for one full-time counsellor, he had a full active case load brought over from the contractual interim funding. We targeted a maximum of 30 clients at any one time and hoped to serve 100 to 125 families annually. This projection of our capabilities was really optimistic. One worker could not carry the burden of 30 families, at least not of the severity that came through our doors. Length of stay was extended because of the complexity of the cases, and of course then our waiting list grew. Our base funding of \$52,000 would not support expansion of services. The sponsoring agency also did not have surpluses to help out with any expansion. The parent program provides management and administrative services as well as office space and shares other operational costs with the children's program. Adult mental health also has waiting lists, is understaffed and is only meeting its budget.

In south Simcoe county we are the only service of its kind offering the traditional office-based assessment and treatment. We have a psychiatrist who consults to us on a regular basis. We offer groups and try to serve the mix of clients who come our way. Grossly underserved are the severely psychiatrically disabled and those families at high risk due to family breakdown and being away from extended families. We are unable to address the issue of increasing recognition of sexual abuse.

The partnership with Blue Hills community program was not viable as the ministry had expected, as it too was

at capacity and with waiting lists. We have turned families away by putting a freeze on our referrals. We have referred to other agencies in the county. We have approached the ministry for assistance and enlisted the support for doing this from the public and from our colleagues. Still, adequate funding is not available.

Our figures show a fluctuation in the volume of referrals over the last two-year period from a minimum of nine to a maximum of 45; this would take place in our quarterly. The waiting list has also fluctuated from a maximum of 47 to a minimum of eight. Part of this fluctuation is reflected in the freeze we have put on referrals and by the reluctance of the community to refer to us because of the extensive waiting period. At present, we have a six-month waiting list. A survey of the general practitioners in our catchment area has shown that they tend to refer elsewhere, usually to private practitioners, but many of these families cannot pay and this is not a viable alternative for them. Most physicians still refer to us, although some have decreased the referrals they send. When they do refer, they send the most difficult and severely identified problem families our way. Very few of the general practitioners in our area do any of their own family counselling.

When full, our centre has suggested alternatives including schools, doctors, private practitioners and other agencies. We try to offer services in Simcoe county, namely, in Barrie. This door is also shut to us as they too are stretched and do not accept referrals from outside their immediate catchment area. Families weather a crisis and it fades away for a while. Sometimes the families cope but many times the situation worsens until service is available. Also, so much more damage may be done and everyone has to work harder and longer to treat the family by the time they finally get to us. It becomes a rather revolving syndrome.

What has gone wrong? In 1988, when proposals were invited for a counselling service, I was so hopeful. There were only so many dollars for this area and I reasoned that our facility was eligible as we had been providing a service co-located with adult mental health. We had a competent counsellor in place and we were centrally located in the south part of the county. The other two agencies, that is, Blue Hills and the Thompson centre, also had an excellent plan, which could be funded partially from their existing facilities if surpluses were available. As it turned out, all three proposals were funded, not one larger program in the area. That limited, I believe, each one's growth potential. I would like to work on an evaluation of this kind of programming and funding. In the meantime, I feel that we at the Mary McGill Community Mental Health Centre are stifled in our growth despite attempts at seeking funding, and we have no surpluses with which to work.

What this means for our service is a treatment program which rushes people through. As manager, I literally nag the staff about length of stay. I push to have inactive cases discharged. I am quite rigid about meeting the demographic and age requirements and to do anything to admit the next person who is waiting to be seen. We have established groups to serve more people at one time. We

have had parent meetings and used the telephone to offer interim assistance where possible.

1340

The Ontario Child Health Study of 1989 states that in the central region, 18.4% of children suffer psychiatric disorders but only 4% use a mental health and social service. This indicates to me that we are grossly underservicing this region. The services in South Simcoe, though, are stretched. How many people are we not serving? This study is inconclusive and does not address whether services are available in any one area or not.

What has been suggested in planning strategies through the 1988 consultation paper *Investing in Children* is collaboration, a service spectrum, community and agency linkages, to name a few directions. Is this happening? I would hope that the collaboration between the Ministry of Health and the Ministry of Community and Social Services will continue. Also included in the collaborative process should be the ministries of Education, Correctional Services and even Housing. The schools in our area have cut back guidance services to exclude personal counselling to adolescents. There is also a lack of diagnostic service available. In the elementary school system, the behavioural personnel are not doing front-line work any more but only act as consultants to the teachers. I find these cutbacks undesirable. The education system has been a forum for identification of learning problems and correction of these problems that can lead to behavioural problems. One step in a positive direction is that a preschool screening program will include identification of high-risk families for psychological and behavioural problems, along with providing parenting skills and programs to those families that need them.

It should be part also of every agency's mandate to address prevention and promotion. To do this, the public must be included and encouraged to join with the service providers to help each other. Use of non-professional volunteer services should be encouraged where possible. Why could we not use the energy and wisdom of our older citizens to develop community helpers?

Although we need a plan for the future of children's mental health, there is also great need now. Once we identify need and risk, we then ask people to wait for up to 12 months for treatment. The gap between need and service availability is a dilemma for us in all of Ontario that is not readily solvable by saying, "Give me more dollars." We must look carefully at how we can effectively use our communities. There needs to be a balance between the demands of the taxpayers and their ability to pay. I would like to see in south Simcoe county a child and family centre in its own right with clinicians, home workers, management and support staff. The linkage and collaboration would be there with informal networks, with physicians, adult mental health, schools and other community agencies.

Because of the overextension of the Mary McGill Community Mental Health Centre and the child and family services, I rated us at a 1 because of limitation in funding, staff and resources, all needed to plan and implement suggested programming. With the joint planning efforts of the

district health council in our area and government ministries, I still have hope for the future.

I thank you for inviting me to give my input into the future of children's mental health. May we all work together towards our goals.

Mr Jackson: Thank you very much for an excellent presentation. I am fascinated by your comments on the last page, talking about the cutbacks in guidance services to exclude personal counselling to adolescents. I am quite familiar with high school programs and OSIS and all of that. Can you describe it in a little more detail? First, we are talking about the Simcoe board?

Ms Moir: I am talking about the Simcoe board, yes.

Mr Jackson: Public or separate?

Ms Moir: Public, mostly. I am most familiar, I must say, with Banting Memorial High School, which is the largest secondary school in Simcoe county with an enrolment of around 2,000 students. The guidance counsellors there had been providing counselling to troubled teenagers, using as a linkage and often as a backup. But through the director, from the board, they are to be delivering vocational counselling services only and not be doing personal counselling. We feel this is a great loss because I know, again speaking in our own area, that Banting has had some good people there.

Mr Jackson: I appreciate your clarifying that. I am familiar with some programs, but these programs are mostly evolved to respond to a growing need in the community or in direct response to a crisis which had great publicity. You are familiar with some of the suicide statistics which are shared internally professionally but not shared publicly. None the less, there is some reaction. It seems this is an area we should be trying to examine, to the extent that these programs are not formally entrenched by board policy nor funded specifically by the province through the Ministry of Education and reflected in their grants. I appreciate you bringing that to our attention. I know one of your area representatives, Jim Wilson, had brought this to our attention in our caucus. He has his staff here today, but he has a conflict in his schedule; he would have liked very much to have been here.

Ms Moir: Yes, I miss his face here today.

Mr Jackson: But he did share some of the points you raised in your presentation with our caucus and wanted you to know that.

Mr Beer: I am interested in your comments in terms of the local level and coming to a decision around the three programs. I am somewhat aware of the Blue Hills program, because they have a base in York region as well. How do we get at determining at the local level, whether it is Simcoe county, being that area, to make some of the decisions at times and to participate in the evaluation? I sense from your comments that your thinking is that for an area the size of Simcoe county it would be best, perhaps, to have one agency that had an overall responsibility for children's mental health. I know you have sat in and listened to some of the presentations and the Children First

document that came forward that looks at how might we organize both locally and provincially.

What would you like to see at the local level if we bring together the providers of children's services so that some of these kinds of decisions would be made? Would you like to see some kind of body that could have some power over the distribution, allocation of dollars? How specific do we get here? This morning your counterparts from Simcoe County Children's Aid Society were talking about what they felt was an effective program they were doing within the children's mental health area. That may well be so, but there might none the less at some point be a decision made locally: "Let's bring all of this together." How do we go about making those decisions, where you, as part of that community, would feel, "All right, it may not be what I wanted, but there's been proper consultation and this is the way people feel we ought to go"?

1350

Ms Moir: First, for all of us in south Simcoe, when we put this proposal together—and I worked very closely with Blue Hills in our own presentation to the ministry—I think we grossly underestimated the need despite studies; that is hindsight, unfortunately. We had hoped to have a closer working relationship with the home-based programs, such as Blue Hills was funded for, in ours, the traditional base. We do try to share cases back and forth. We have tried a joint management, but we cannot afford that, and we cannot afford—we both have very extensive waiting lists.

I think that we have to look elsewhere, whether it is—I have mentioned the Ministry of Education and how even the preschool screening program—so I hark back to the idea of prevention and promotion and working together, with perhaps a central entry point. I think our district health council is actually looking at that in terms of mental health. I would have appreciated my visit here being the week after next. Next week the district health council is doing community consultations and coming to Alliston to hear from the providers and consumers there about mental health planning.

But I have heard other ideas in Collingwood, talking about using the children's aid society, using the Ministry of Education. I do not think it really matters. I think it has to be investigated in each area where we start, but I think it does need a central—I kind of picture a wheel, the hub—a centralized area where we can tap into informal and formal services and use the various ministries that fund us.

The Vice-Chair: Are there any other questions? If not, then I would like to thank you for making your presentation before us here today and wish you well.

McMASTER UNIVERSITY

The Vice-Chair: I would now like to call upon Dr Dan Offord, McMaster University. Welcome to the committee. I would also like to remind you, if you were not here earlier, that we have half an hour. If it is not used up entirely, it will put us further ahead, but do not concern yourself with our problems and predicaments. Use the entire half-hour in whatever way you would like to divide that up.

Dr Offord: Thank you. I have a handout that is being handed out here. I will just wait until everybody has a copy of it.

I am delighted to have the opportunity to present briefly to you some thoughts I have on the charge of the committee. The handout has the main points I am going to make, and I also have included attached to the handout two resource papers. They go into some detail about the points that are summarized in the handout.

I am going to begin with some pertinent findings from the Ontario Child Health Study, which was a community study which gathered data on a random sample of 3,000 children between the ages of 4 and 16 in the province. It investigated the mental health of these children, the physical health and the alcohol, drug and tobacco use, as well as risk factors and utilization of services and associated impairments.

From the Ontario Child Health Study it was found that the prevalence of one or more psychiatric disorders in Ontario children 4 to 16 years of age was 18.1%. So the first point to make about children's mental health problems is that a significant number of children in the province suffer from clinically important mental health problems. They are not rare.

The second point is that children with one psychiatric disorder are at increased risk for other psychiatric disorders. Further, children with psychiatric disorders are at increased risk for other morbidities or harmful outcomes, such as poor school performance, chronic health problems and alcohol, drug and tobacco use. Just think of all the things you do not want for your kids. They tend to pile up in a significant minority of children. Thus, children with lowered life quality in Ontario have a combination of disorders or conditions which are not the mandate of a single ministry.

Third, according to the study, children with one or more psychiatric disorders, compared to those with no psychiatric disorder, are four times more likely to receive specialized mental health or social services. The specialized services include places like where I work, Chedoke Child and Family Centre, other child mental health centres, children's aid, the courts, family service associations and private practitioners.

However, only one of six children with psychiatric disorders has received this specialized service in the past six months. Further, from our data, over half of the mental health/social services were being devoted to children without any of the four disorders measured on the Ontario Child Health Study. There may be other reasons, good reasons, why they were receiving those services. It could be that they have other disorders we did not measure, that there were other reasons to seek these services out except for psychiatric disorders in the children. However, it does raise the issue I will talk about later of the targeting of services.

Lastly, family doctors and paediatricians in Ontario, with first-dollar universal health insurance, see almost 60% of the children every six months. The schools, of course, deal with all children of 5 to 16 on a regular basis.

What are the implications of these findings for the delivery of services?

First, it is clear because of the magnitude of the problem with children's mental health difficulties that specialized mental health social services can never adequately provide services for children with emotional and behavioural disorders.

Second, it is going to be extremely important that the specialized and expensive services be targeted to those children most in need of them and who can benefit from them.

Third, family doctors and paediatricians in the schools should be centrally involved in providing mental health services to children and their families because they see these kids on a regular basis.

Fourth, in addition to servicing identified children and their families one at a time, no matter how that is set up, there is the gnawing feeling in the field that it is going to be important to develop public health approaches which focus on populations of children at risk.

Examples of such programs include milestone programs where children at a particular stage in the developmental course are the focus. For instance, all children as they enter school in grade 1 could have certain programs in place. Second, there are high-risk programs. Groups of children at increased risk for emotional and behavioural problems are the population of interest. A major high-risk group in Ontario are the offspring of parents on social assistance. Third are community programs, children at increased risk living in a circumscribed geographic areas such as public housing projects. Over 120,000 children in Ontario live in these large, publicly supported housing complexes.

Fifth, services for children must be co-ordinated across ministries since the conditions that exist within children are not ministry-specific, and comprehensive cross-ministry programs are needed to deal effectively with these multiple morbidities.

As part of the charge, the issue of the waiting list of children for services of the children's mental health centres was pointed out, and I made some comments about short-term and longer-term steps.

First the short-term steps:

Gather systematic information on the children on the waiting list, including the types and seriousness of the problems they have, their family backgrounds and where they live.

Divide up the waiting list group into those who need immediate individual attention and those who do not.

Ensure that the former group receives immediate individual attention and provide the latter with less intensive group or community interventions.

Encourage children's mental health centres to review their case loads with a view to determining who does not need time-consuming, individually focused intervention but for whom the appropriate intervention is less intensive and perhaps not individually focused.

1400

Second, longer-term steps:

Institute a uniform data collection procedure on all children and their families touched by the mental health/social service system. The number and characteristics of these children being served by the system are simply not known in any systematic way.

Use the data to determine the relative size of the populations of children with different types of problems and use this information to plan appropriate services.

Combine this information we would have on the children touched by the system or served by the system with the already good information we have on children in the community. Then we will be able to investigate the appropriateness of the population served by specialized mental health/social services. A prerequisite to do that means that you have two good data sets, those children being served and those children in the community. With that prerequisite in place, we can then make sure that the mental health/social services are targeted to populations most in need and most likely to benefit from the services.

Determine from the existing literature what interventions, whether they be individual, group and community, for children with mental health problems are known to do more good than harm for children with specific types of problems and, conversely, determine what interventions are known to do more harm than good or are ineffective for children with particular kinds of problems. Make sure that this information is widely available to the staffs of children's mental health centres so that their practice is based on the best available knowledge.

Institute a comprehensive research program to increase our knowledge about the effectiveness of prevention and treatment programs for children's mental health problems. Different delivery systems should be included in this enterprise: individual work by mental health and social service workers, family doctors, paediatricians, school staff. Different approaches should be investigated, individual, group and community, and the intervention programs should not be restricted to the mandate of one ministry but should involve multiple ministries.

The goal is to move towards a delivery system of children's mental health and social services which provides effective services at reasonable cost to all children and their families in need of them.

The Vice-Chair: We have Mr Malkowski first.

Mr Malkowski: I am very impressed with your presentation. There are two areas on which I would like to ask for your comments. One area is in the mental health training for children's specialized services. Do we have enough resources related to training in the non-traditional approaches in Ontario?

Dr Offord: Non-traditional meaning what?

Mr Malkowski: Traditionally we have used a medical approach to services and now we would like to take a more humanistic approach and provide non-traditional treatment. There are doctors or practitioners who still use the medical approach.

Dr Offord: I am not clear exactly what is known by the medical approach. What I would say is that I think there will always be a need for services which are

delivered to identify kids and their families on a one-to-one basis. In those instances, it is important for the practitioners, whether they be medical doctors or non-traditional, whatever, to institute interventions that have been shown to do more good than harm so that ordinary clinical care, no matter who it is delivered by, is based on the best available evidence about what works.

Second, as I have indicated, it is clear that, even though that is done to the best of one's ability or system, there is going to be lots of room for other intervention efforts which will include, for instance, prevention programs for groups of children at risk, such as those in public housing, or high-risk groups, such as the offspring of mentally ill parents or the offspring of parents on social assistance.

I see that the delivery system for children's mental health problems will be a combination of those that are going to be done on an individual basis and those that will be delivered on a group basis.

Mr Malkowski: If we are looking at comprehensive research projects, would you plan to include the role of the consumers in this research project?

Dr Offord: Yes, absolutely. I think, for instance, if one is to do a research project in the community, that it is clear that one does not go in singlehandedly from a professional side and impose some program on the parents and children in that community, but the consumers, in that case the tenants or the parents and the children, are actively involved in determining what kind of program might be implemented and what the evaluation strategies might be. Clearly there is room for a lot of community development and participation by consumers in any comprehensive program to reduce the burden of suffering in children's mental health problems.

Mrs McLeod: I am very much supportive of the goals that you have outlined here and I think you would see them as being consistent with the Maloney report that has recently been tabled although, as I have said earlier in the committee, while it recognizes the support in the delivery through schools, I am not sure that it goes the further step of recognizing the importance of providing support close to doctors' offices.

I am becoming a little bit more concerned as our committee deliberations go on that we may almost see that decentralization in service delivery through the school as a hub as being an alternative to treatment provided in children's mental health centres. I wonder if you could help us a little bit. You talk here about the number of children with psychiatric disorders and I assume you are referring to some very specific syndromes of children who have some particular and often severe problems. Where do you see those children being treated? Can they be treated through the school intervention program? Is there a continuing role for the children's mental health centre?

Dr Offord: I think it is clear that the thing about children's mental health problems is they are diverse and include a wide spectrum of disorders, everything from kids who are chronically aggressive and lie to children who have serious and lifelong debilitating disorders such as autism.

I think the thing to remember about children's mental health problems is they are very diverse and a heavy burden of suffering, and the comprehensive program is going to have to include different elements. For instance, there is always going to be a place for individualized work that is done at the children's mental health centres because some kids need that. My plea there would be to make sure that the interventions are based on the best available evidence; not what people have been trained to do, what they want to do, but what appears to work.

Second, there are all sorts of other programs where the school could be central. There is good evidence, for instance, that what kids at risk need is the best outside-the-home programs this province can provide. What happens to economically disadvantaged children and children in public housing complexes is they tend to get the worst of those programs, whether they be recreation, summer camps etc.

There is beginning evidence to suggest that if you give these kids the best of the outside-the-home programs for groups of them, that can make a difference. We see again that there would be different elements of a program on a group basis that could be launched in a school that I think would be very helpful.

The third point I would make is about the school itself. It is clear that here you have an opportunity to work with groups of kids and the peer group, and there is beginning evidence that if you want to prevent antisocial behaviour, one of the most troublesome mental health problems in kids in Canada and Ontario, one of the ways to do it is to begin to pick these kids up early on. The thing about antisocial behaviour is it begins small and grows. Pick them up in kindergarten and grade 1 in school and do a combination of interventions, including teacher training, social skills training and academic remediation, which was launched in the schools and which may be able to reverse the course for these kids.

Mrs McLeod: Would you also believe that part of that school program would need to provide for family intervention, which would not be done by a classroom teacher and would therefore need some trained personnel based in schools?

Dr Offord: That is right. I think another interesting program that appears to be effective as far as we know is parent management training. If you offer the program, a lot of parents can gain skills which will help them deal with their kids. We need to do a lot more work. What happens, as you might expect, is the parents who need it the most are the ones who are easiest to engage in these programs. One has to do further work to see how to help these parents who are having more problems to stick with the program.

Clearly the program is going to be based in the schools, but the personnel would not all be school personnel involved in these programs. I would include family doctors and paediatricians. See these kids. Nobody knows what to do with those who have behavioural problems. No one has ever studied that. I would include recreation. It is a very

big thing in Ontario and these kids who need it the most have the least of it.

Mrs Witmer: Thank you for your presentation, Dr Offord. You mentioned just briefly now again that there was a central role for the family doctor and the paediatrician to play along with the school, and then as well the need for recreation. What role do you see the doctor and the paediatrician playing?

Dr Offord: The data are clear that parents go to the family doctors and paediatricians, and our follow-up presented today suggest they talk all the time about the behaviour problems their kids are having. That is one of the places they go. I think what needs to be done is to train family doctors and paediatricians in what kind of interventions they can do on a short-term basis that will be effective for these people and what kinds of kids they see need to be referred for more intensive services. But here I think is a large cadre of people who see the kids and are clearly doing something for them for the complaints being brought. What I am putting in a plea for is to be able to upgrade their skills and to study the effectiveness of that vague delivery system.

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Mr Owens: I guess my question is more of a statement. Since we began these hearings, we have been struggling with the issue of the massive waiting lists. I think you are the first presenter who has come forward with a reasonable method of dealing with that issue, and both your short-term and your long-term recommendations should be applauded. I guess my question is, when could we start to get these waiting lists down—as we talked about earlier, even one child on a list is too many—to get them into some sort of manageable proportions? Why has this not been done in the past? Why are we just accumulating kids on these lists instead of going after the strategies that you suggested in your paper?

Dr Offord: I do not know all the answers to that. I think that part of the time, with these kids and stuff like that, what happens in the children's mental health field is that you are so pressured to service kids that it is just like breaking down the door. What is needed I think, in addition to good people on the front lines, is people to take a look back a bit and see what the heck one might do on an overall basis. I am putting in a plug for that. I think this could be instituted fairly quickly.

I think we have to know who is on them, how badly off these kids are. If the kid on that waiting list is suicidal, clearly he has to be seen. That is dangerous. If there is a single-parent mom who is having some difficulties disciplining her young boy, the evidence as we know it now suggests that she can be helped most effectively by a group approach with other single moms, with parent management. So I think one should divide the waiting list into more homogeneous subgroups of kids all of whom would not need expensive individualized treatment, I would think.

Then again, I would put in a plug on the other side for children's mental health centres such as our own. Let us take a look at the case load and begin to see to what extent

ome of the kids already being seen, and their families, could be seen and benefit from a much more cost-effective approach. It might be defined groups. For instance, if all these kids are coming from one school, it makes sense not to see these kids individually. Go out to the school and see what can be done in the school. So I think this kind of thinking is involved in trying to get the waiting list down.

Mr Owens: Further to your point about checking the treatment these kids are receiving, is it actually being effective or are we just throwing kids into specialized programs, where they could perhaps be placed in a less intensive environment.

Dr Offord: Correct. If you had to say what the biggest need is in children's mental health, the biggest need is to find out what programs are effective, do more good than harm, for which kids. It is not that we do not want to do more good than harm, but I think in the majority of the clinical effort we do the best we can but we are not really sure to what extent we are doing more good than harm for the kids we are seeing.

Ms Haeck: In my role now as an MPP, I have been made aware quite tangibly on numerous occasions, although I have seen these things in the past much more in an observer status, that there is great concern about the psychiatric community, the delivery system. I know there are a number of members, much more in the medical area, who have received some negative comments from receivers of their services.

There is one thing that has been briefly touched on by a number of people this morning. I was just sort of looking at your comments and hoping to get some direction on professional renewal, education of professionals. What do you see would have to be done to keep things flowing in that area?

Dr Offord: There is not a simple answer to that. I think two things come to mind. One is that I think it is important for the field to know in Ontario what the state of knowledge is about the different interventions that are being commonly employed in mental health centres, and to be able to say to people on the front line, "Listen, these are the things that appear to work; these are the things that are not effective," and to bring their clinical practice in line with the kinds of things we know.

I think there are two things involved. One is that you have to get the information out. Someone has to know that stuff and write it up in a way that will be appealing to front-line workers. Second is to make sure that happens.

Another aspect of that is clearly for professional groups to make sure that they are trained. The problem, and I can speak for child psychiatry because I am a child psychiatrist, with child psychiatrists is that they tend to keep doing all their lives the things they have been trained to do. They are a product of their training and it varies depending on the centre. It used to be McMaster was big on family therapy and someone else was big on something else. The fact is the field has moved a lot from that. We know a lot of other things. I think it is clear that people should be brought up to date and be brought up to date concisely on these things so that clinical practice is in line

with the best available knowledge. Now what happens, at least in settings that I am familiar with, is that people tend to do their own thing. That is simply not good enough. It is not the cheapest and it is not the most effective way.

Ms Haeck: I am with the Ministry of Colleges and Universities as the parliamentary assistant. Do you have any recommendations for that area as to what programs should be adjusted to fit the kinds of concerns you might have around staff development?

Dr Offord: It is again the same general theme. I am very much in favour in psychiatric training programs, the training of social workers etc, that their teachers do not teach them just what they were taught but that they are very concerned about critical appraisal, about effectiveness and cost of services. What we want to know is, how can you raise the life quality of kids with these problems in Ontario? There are large groups of them. That is going to take people who know, who have a critical appraisal of the literature and can employ it effectively.

Mr Jackson: Thank you, Dr Offord. It is the second time in a little over a year that you have been before the committee. Last time you were a lot more controversially received, but appreciated very much. At that time we were dealing with early childhood education, as you recall.

Maybe I am stating the obvious when I ask you this question, but I think we may be missing part of the point about access points to children at risk and their rights. I think one of the reasons there is that this infatuation with the school is partially because the law protects society because of its custodial role with the child in a school setting. The other opportunity, of course, is through a court referral where a judge specifically orders a child to receive treatment. You would be familiar with the recent report that was allowed to become public in the last four or five weeks which dealt with a child's right to reject service provision and support.

Perhaps you might just briefly comment on the significance of the school and the role it can play in terms of it having this custodial function, where a child can walk away from many settings where support and care is given, but it is harder to do that in a school setting. I think we missed that point and it has not really been touched upon, but there is a reason for this discussion around schools aside from their academic mandate.

Dr Offord: I think two points come to mind. The first one is that clearly you have to get a situation where the kid can stick with the intervention, where you have a chance to do something. Let me just tell you what the literature showed for years and what the big advance has been. You look back and say it is obvious.

If you get a kid who is kicking up and he is a real pain, I was taught that what you do is you take that kid aside and you try to help him. You make him into a better kid. Then you put him back into the peer group situation. What you find, and everybody finds the world over now, is that when you do that the fact is you make the kid better when he is by himself. You teach him all these skills. He knows how to get along and all that stuff. He goes back to the peer group and they do not think he has changed at all no

matter what he does, so within 15 minutes or half a day he is behaving exactly the same way he did before.

The way to help that kid is to involve the whole peer group. That is obvious. When you do that you can help the kid. The point is that here you have an opportunity in the school to have a ready-made peer group to do something about it.

What happens and appears to be effective is you take the peer group aside and say: "Listen, kids have different kinds of problems. What do you think about kids who do not fit in? How can we help them?" You also have the kids come up with ideas. That kind of approach is very effective. So I think the schools are a very effective source of the kinds of things that can be done to raise the life quality of kids that cannot be done in other settings.

Mr Jackson: Post-suicidal it is almost critical. In some of the peer group incidents of attempted suicide following a successful suicide attempt, I have seen numbers in my own riding as high as 22 students in a school attempting it over the course of a year subsequent to a successful suicide. It just crystallizes that point almost too well.

Dr Offord: That is right, and I think suicide is one of these things that has a contagion effect. If one kids does it, it puts other kids at risk.

Mrs McLeod: It comes back to trained personnel.

Dr Offord: Absolutely, but there is no other setting that can provide this peer group intervention, even if you have the trained personnel. I cannot do it in my office. It does not do a darn thing. I would like to think I could do it. It does not do any good. It is a waste of time and money for me to try to do it. It is far better to do something with the peer group in the school.

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Mr Beer: Briefly, I suppose that one of the things at the end of all this that we want to do is to put forward some recommendations that will move the yardsticks. Clearly in 12 hours we cannot become total experts. But one of the things that we have been wrestling with is the question of structure. Colin Maloney's report has suggested a way of looking at that both at the provincial level and at the local level.

I just wonder, from your experience—you have met and talked with so many people working at the local level—how structured do you think we have to become in terms of the delivery of children's services, the allocation of funds, the determining of who is going to do what to whom? How much of that can we really structure locally to make for a more effective system and what are some of the things that we have to be aware of? I am assuming that you have looked at a number of different approaches throughout the province. I think we can see how we might do that provincially, in dealing with a number of ministries in bringing that together, but how far can we go locally?

Dr Offord: Clearly it is going to vary from community to community, but I think the first thing is that if you are going to do something in the children's mental health area all the actors have to be on board. I think there is a lot to be said for local committees that include not just

Education and Health and Community and Social Services, but include Housing and Tourism and Recreation. These people are together and then they begin to think about what are the big problems in the community.

The beauty of it is that these problems may vary from community to community. I think then they are going to perhaps need consultation—perhaps it exists within—to know what to do about these things. I think the advantage of the local stuff is that they can address local problems provided all the actors are there.

The other thing I would say is that accountability has to be built in and so, for instance, the thing we are working on is recreation. Now the fact is that for poor kids nobody knows if they get even their share of recreation dollars, so if anyone is going to do recreation then I would want to know how many kids come out and exactly how much they learn. There has to be an accountability built in for everybody in there. I think that with the local work group on accountability that there are a lot of advantages to doing it on a local level.

The Vice-Chair: I see that you have obviously generated quite a number of questions. That is very good for this committee. We will be wrapping things up tomorrow with our report, so I would like to thank you for a stimulating discussion.

Dr Offord: Thank you for inviting me.

ONTARIO ASSOCIATION OF CHILDREN'S AID SOCIETIES

The Vice-Chair: Our next set of presenters are from the Ontario Association of Children's Aid Societies: Mary McConville, executive director, and Bruce Rivers, executive director of the Children's Aid Society of Metropolitan Toronto. Welcome to the committee. Again, I will repeat that you have a stringent time limit of a half-hour. Please commence.

Mrs McConville: I would like to thank you for the opportunity to appear before you today to discuss the important and troublesome matter of children's mental health services in Ontario and the need to improve these services. Although we wish to speak to you today primarily from a child welfare perspective, we would like to begin by making some general observations about the subject of children's mental health in Ontario.

The committee obviously is aware of the important epidemiological work in this area that was done by Dr Dan Offord, who has just preceded us. The study is a watershed document in our opinion that proposes, conservatively speaking, that at least 18% of our children suffer from a serious mental health disorder. In reality, if we consider a variety of other conditions which are well documented and which are not represented in that study, up to 30% of the youngsters in our communities are affected by mental health disorders during their childhood years.

These epidemiological indicators alone tell us two things. First, we will never have enough services to address a problem of this magnitude if services are viewed as the primary response to the problem. Second, the indicators also suggest that there are inequities in the health status of our citizens, especially children, which appear to

connected substantially to factors such as poverty, ethnicity and other factors such as public housing.

The relationship between poverty and health outcomes has been well documented. Children who live in poverty are 40% to 50% more likely to be of low birth weight, premature or with growth retardation and experience a 10% higher death rate from all causes. These children are also twice as likely to be afflicted with psychiatric disorders and poor school performances than non-welfare children.

These compelling facts, and there are many others which I am sure will be placed before this committee throughout its hearings, can only lead us to conclude that in addressing the mental health needs of children, we must think in a broader context than the adequacy of our services. We believe that the government must first and foremost concern itself with the necessity to promote the development of a better societal capacity to ensure the wellbeing of children in order to reduce the number of special needs cases that require the use of the safety net.

Simultaneously, we must attend to assessing the proper role of our specialized services in relation to that children's agenda, which does not exist in the province of Ontario, and as Dr Offord pointed out, the proper targeting of these resources. Within that context we can then properly assess the adequacy and the effectiveness of the services that are provided to vulnerable children and families.

The recently published document entitled *Children First*, a report of the Advisory Committee on Children's Services to the Ministry of Community and Social Services, is an excellent framework within which to consider the development of strategy to support the wellbeing of children, and also to improve the capacity and the impact of a variety of services that are applied to the problem of children's mental health.

The United Nations Convention on the Rights of the Child is also a useful document in assisting with the development of principles which should guide governments in forming social policy with regard to children.

Those principles are: Childhood is entitled to special care and assistance. The child, by reason of physical and mental immaturity, needs special safeguards and care before as well as after birth. The child, for the full and harmonious development of his or her personality, should grow up in a family environment and in an atmosphere of happiness, love and understanding. Children who live in exceptionally difficult conditions need special consideration.

There will always, then, be a need for a safety net that captures those children and families who are broken and who suffer from a variety of social, health and psychological problems. Child welfare services and children's mental health services are two of the cornerstones of specialized services in this province.

Children's aid societies in Ontario primarily service children within their families and their communities, providing service to over 152,000 families in 1989. We also provided substitute care to over 19,000 children during that calendar year. On any particular day in this province, there are approximately 10,200 children in the

care of these societies; 53% of them are cared for in foster homes and the rest are cared for in a variety of paid or free institutions, group homes, etc.

Children's aid societies received more than 19,500 allegations of child abuse in 1990, an appalling increase of 2,300 allegations over 1989 and an increase of 100% since 1984. Although the numbers of abuse allegations and documented cases of abuse and neglect have skyrocketed, none the less the number of children in care has significantly decreased. This is partly because of the thrust of the new act which demands the least intrusive approach, but also because of improved methods of providing services to children and families at risk.

Having said that, there is a downside. Because societies are required to exhaust all possible measures by the courts before admitting a child into care, more and more children who are being admitted are being admitted in extremely damaged condition. Children's aid societies consequently are required to parent both on a short- and long-term basis many of the most damaged children in our society. It is essential that we have a variety of caretaking options, consequently, to ensure for the adequate care and treatment of these children.

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The proclamation of the Child and Family Services Act, in our view, was a great leap forward in significantly reducing legislative barriers to service and treatment by virtue of the integration of a number of pieces of children's legislation. Some feel that moving the responsibility for children's mental health back to the Ministry of Health will improve things. We feel this will only create more fragmentation.

The government should rather consider more integration of ministry structures to better support children, because we also believe that co-ordination across ministries in and of itself is not sufficient. The service system in the province of Ontario, which is essentially a transfer payment one, despite integrated legislation, is none the less not supported by a clear vision of social policy and service delivery, or by adequate funding mechanisms, information systems or other systems management tools.

In short, service providers do a significant amount of good, given very limited resources, but we could do a much better job if we had basic support, such as the information system which Dr Offord just referred to, with which to plan and evaluate the impact of our services and effective mechanisms to ensure that children do not get caught in systems or are denied access to services.

There is no question that the problems of children's mental health go well beyond some of the inadequacies of the legislation or the waiting lists in various communities for services and we must be vigilant in our attempt to understand the problem so that we do not end up with simplistic answers that in the end are no solution.

Children's aid societies in the province, despite having responsibility for many of the most difficult children, are frequently unable to gain access to children's mental health centre beds, even in those communities where there is a wide spectrum of services and a large number of services. Many factors come into play here, the underfunding

of some of those services that have beds but also insufficient staff, rigid eligibility criteria, the lack of innovative programming in some instances and the lack of planning in the use of residential beds.

At this point, I will just turn briefly to the director of the Metro society to give you a more specific feel of how that translates into the impact on children.

Mr Rivers: The placement problem for hard-to-serve children in residential facilities became so acute for Metro Toronto societies recently that they requested that the Ministry of Community and Social Services make a special attempt to deal with the local access crisis.

It is worth noting that the occupancy rate of local children's mental health centres in the Metro area is frequently as low as 74%, while local CAS occupancy rates at admission assessment residences have consistently exceeded 100%. It is also important to note that children's aid societies do not have the latitude to refuse service and develop waiting lists. The children's mental health centres' waiting lists are composed of families in the community as well as child welfare clients.

We believe much of what is creating the waiting list crisis is the reduction in available foster parents. For example, between 1982 and 1989, the child welfare sector experienced a 25% loss of foster parents. That percentage, by the way, is higher in Metro, closer to 50%.

When one looks at the number of children in mental health facilities who are wards of the societies, and the number is often remarkably low, there exists an all too frequent bias against accepting these children because they are considered too disturbed. It is a fact that many of the most disturbed children in the province languish in CAS-operated admission assessment facilities, frequently breaking down, and a large number of our children are placed out of sheer necessity to private group homes, often miles away from their local community, which is a terrible disservice to them and their families. Many are placed in foster homes or agency-created, staff-operated resources to fill the gap that is not being met by a residential resource system.

Children's aid societies themselves and the private group home sector have been forced to fill the gap left by the children's mental health centres in caring for highly disturbed children.

To give an illustration, one in three children referred by our agency to special placements required intensive long-term treatment, and by that I am referring to up to two years. In one year, 100 such children were referred to treatment facilities and only 33 were placed. The rest were not accepted because they were considered to be too disturbed. These children were eventually placed in foster care or in private group homes, often out of their home communities.

We recognize that many of the youngsters in children's aid society care, because of the severity of their problems and early deprivation, will not do well in residential treatment that in Ontario is, at best, a short-term resource. More long-term and crisis beds are required, but alternative methods of caring for these children must be supported, such as treatment foster homes and therapeutic foster care. Child management support in the home, group

support for foster parents and higher per diems are all part of a spectrum of supports that must be available to caretakers. Foster care providers in the 1990s must be recognized as professionals who are expected to care for very disturbed children. They will require training, decent compensation and staff support, not only from child welfare professionals but from the mental health professionals in our children's mental health system who must be willing to apply their expertise in different ways, such as through case and program consultation.

We would like to refer you to an article in the Journal of the Ontario Association of Children's Aid Societies, which discusses the value of consultation between child welfare and children's mental health. It is item 4, and to help you, there is a summary at the end that I think will lead you to some practical solutions. I would also like to refer you to an OACAS fact sheet, which is green, inside the Journal, which indicates from our annual survey the very low rates of compensation for foster parents in child welfare. By the way, the average is anywhere from \$15 to \$18 per day, depending on the age of the child. Spending more on these kinds of essential supports and less on regulation, for example, would allow us to enrich a range of services. These are some of the practical solutions that we would suggest in getting the list down and expanding our foster care system.

Mrs McConville: It must also be said that children's mental health professionals and others are not clear about the mental health needs of discrete populations of children, although they know a considerable amount about the needs of individual types of cases. Consequently, professionals are not in a position, without more research, to define strategic ways to secure the level of resources required to address apparent needs.

More research is required to determine what kinds of children can best benefit from residential treatment and what kinds of children are best served through other methods of service delivery. We need to develop community strategies and service strategies for reducing risks for those at highest risk. Service providers themselves should not be able to define service responses in isolation of the clear articulation of community needs, as is presently the case. They should not be able to unilaterally control access to scarce and expensive resources such as children's mental health beds.

Accountability mechanisms must be put in place so that services relate to community needs, and we further need to create incentives to comply with regional plans and other policy requirements that emanate from the funders and local planning bodies and community groups.

In conclusion, we believe there are gaps in service. We no doubt could use more residential mental health beds, but some immediate relief or short-term solutions could be provided by doing a much more efficient job of allocating the resources we have, supporting alternatives to residential care for those children who need it and planning more carefully and in a targeted way for any expansion of the residential system. We have many examples throughout the province of the value of the collaborative efforts between child welfare and children's mental health profes-

onals. For example, in the city of Toronto we have child welfare and mental health professionals out of the specialized safety net working directly in schools, such as Ryerson Public School, with the sole purpose of supporting teachers so that they can identify risky and vulnerable kids and families much earlier and apply interventions, obviously at a stage when they are much more likely to work.

We, in addition, must expand these kinds of efforts, which do exist here and there throughout the province but in a very fragmented kind of way, and this expansion of alternatives can only be provided through ministry leadership and funding incentives. We must kickstart these efforts with an infusion of funds to keep services that are presently there afloat while we shift our structures to reflect another approach.

In the long term, a targeted reduction in the incidence of health inequities through strategies such as those put forth by the Social Assistance Review Board, which target poverty and early intervention and prevention strategies, is the only hope for changing the balance between the need for and the availability of specialized resources such as children's mental health services. Only a province-wide health strategy which promotes the wellbeing of all children will enable these strategies to develop and reach fruition. Specialized services, in the long run, should be in less demand in the future, but also should be restructured to reflect a wellbeing model of services and one that does not solely assign its expensive resources to individual case application.

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The Vice-Chair: We will move right into questions. Mr Hope is first on the list.

Mr Hope: I welcome the information you have put forward. The one thing I have noticed is, when you stated about clear policy and direction and leadership of the ministry in itself—and I think that is one of the key important things. I am sometimes wary of putting power into local communities, because, number one, we do not know what direction, and the best interests of the board level, who is on those boards. A lot of times in smaller communities in rural Ontario we have a hard time getting people to serve on these boards, so it is done by a minute group, which may not really see the whole picture of what is happening.

I have to agree with you that we need more direction from the government itself and from the ministry in implementing more direction and clear direction. I think there are a number of plans out there that we are trying to put forward and I think Better Futures, Better Beginnings, which was implemented by the previous government on the research part of it—and he is a member of this committee and I have to commend him on putting that effort there. I think with that focus of starting to solve the problem at the earlier stage—I am glad that you put some of this information about children's aid forward, because it is an issue and I think the community mentality of children's aid, education-wise, is not there. I think more people have to be aware of what the children's aid function is really all about, because in smaller communities I do not think they really know. I am glad you put this forward.

Mrs Witmer: Thank you very much for your presentation. I appreciated the information that you put forward. You mentioned on the final page that you feel the only hope for changing the balance between the need for and the availability of these specialized resources such as children's mental health services is through early intervention and prevention strategies. What strategies at the present time would you be recommending? What do you feel is working successfully and what should we be pursuing?

Mrs McConville: I think one of the most frustrating things for service providers—and I am sure Dan Offord would agree with this; I do not know if he is still around—is that there is already a good deal of information out there through good research indicates that early intervention strategies work with individuals and families as well as with groups and vulnerable populations. I know that is what Better Futures, Better Beginnings is all about and I applaud the ministry's attempt to promote these broader prevention strategies with some significant money over a long period of years.

My frustration is that we have demonstrated many, many times on a local basis and in broader kinds of ways, and not just in the jurisdiction of Ontario, that working with vulnerable populations, for example, works; intervening earlier works. We know that in our own daily practice in the children's aid society. The problem is that we cannot express that experience by way of information that you can roll up in a global fashion so you can learn from it.

We do not do enough program evaluation. We have good professional experience that tells us what works and what does not, but the information is not available in such a way that professionals can learn from it and funders and social policymakers can learn from it. I think service providers at large in the province, and I would include many medical people in this, are doing a lot of good work and their experience is telling them that what they are doing is working, but we are not doing enough program evaluation and we are not doing enough research to document what works. Consequently, when you turn to the funders, they say, "Well, prove that what you do is effective," and we cannot.

Mr Rivers: If I could just also comment on that question, it is interesting to note that last year in Metropolitan Toronto we were funded privately to the tune of \$1 million to experiment with primary prevention, but we were unable to convince the government that such an expenditure was necessary. It was the corporate community that in fact supported the program at Ryerson Public School and it was the corporate community that has supported programs for young mums to get out of their homes and to look at new and better ways of parenting. So there needs to be a look at the children's aid society's mandate as dictated under the Child and Family Services Act. You have to take a closer look at that prevention issue, because presently it is not getting the due attention that it requires.

Mr Beer: A bit in the same vein in terms of looking at some of the things that you have been doing, I was interested in your paper. I think this is the first time we have

talked in some detail about foster parents and their role. I think it would be interesting for the committee if you might tell us a bit about the Homebuilders program that you and your colleagues in Metro have been trying to develop. It seemed to me that had the promise down the road of providing a lot of help in this area. I wonder if you would just share that program in conceptual terms with us.

Mr Rivers: Homebuilders is an exciting program that could have a major impact on the waiting list that you are dealing with. Instead of a child being admitted to a residential program or into foster care, it would see the worker moving into the child's home for anywhere up to 20 or 24 hours a week so that the worker is there at the critical times that the stress is on the family.

This concept has been tried throughout the United States and has been demonstrated to be 80% successful in holding high-risk kids out of care. For the last year or so the Toronto agencies have had before the ministry a proposal for funding that is about \$1 million to implement. That is the kind of kickstart that we are referring to when we say that there needs to be some risk here.

Presently, you will be interested to know that we have, as well, a couple of corporations that are prepared to back the project but cannot pick up the entire bill, so we have been able to convince people throughout Toronto that it is a good idea and we are just waiting to hear now about implementation.

Mrs McConville: I should also say that we did have in several societies throughout the province what we call family support programs, and there are many varieties of them, but the purpose of them is to assist families that are disorganized and have all sorts of problems in improving their parenting skills and reducing the crisis element of a family's functioning so that we can reduce the risk of bringing kids into care. We know these programs work and they have been a large part of reducing the numbers of kids in care by half over a 10-year period, and yet those programs today are vulnerable because, and this goes back to the mandate issue, as money gets tighter and tighter and the ministry tries to control the child welfare budget, which is difficult to control because we must in many instances provide service, it is starting to target the front-end programs, the early intervention programs in our specialized context that have enabled us to keep kids out of care who should not be coming into care, and obviously have, in the bigger sense of the term, reduced costs because it is a heck of a lot more expensive to bring kids into care than it is to service them in their community.

Mr White: I have worked both with the children's aid society in Metro Toronto and with a couple of children's mental health centres. What I am struck with, within the body of your report and certainly within my experience, has been that although we have two different services funded by the Ministry of Community and Social Services, there seems to be more than just a creative tension between these services. There is often a battle royal over a sector, where the wellbeing of the children involved should be the paramount issue. You refer here to the crisis in placements, situations where there were only, say, 74% of

the residential beds in children's mental health centres occupied in Toronto. I understand that Metropolitan Toronto has fewer beds than does Hamilton. Some of these are startling statistics.

At a very practical level, what suggestions might you have in terms of how the Ministry of Community and Social Services might effect greater co-operation between two very valuable services working on children's behaviour and in what ways the ministry presently may not be fulfilling its mandate to regulate children's mental health centres?

1450

Mr Rivers: First of all, the battle royal you referred to is not as expressive as you might have experienced in the past. In fact, I would say the situation has improved. Part of the solution I am going to suggest to you is I think, the reason why. Over the last two years, for example, in the Toronto area office there has been a concerted effort by Comsoc to leverage co-operation. When I say "leverage" co-operation, I think a number of children's mental health centres and children's aid societies realize that if they are going to be successful and focus effectively on the child, they have to collaborate. There is no better way to motivate people around that issue than to make funding contingent upon it.

Mrs McConville: I would also say, to further leverage local planning initiatives where they exist—and of course they should exist everywhere—has to be mandated. You do not ask people to collaborate and co-operate with one another. You tell them they are going to and they will, and they have done in the past.

Mr Martin: One of the questions I was going to ask you has already been touched on by Mr White. I certainly agree with you that leveraging and funding co-operative efforts is probably one of the ways to go in terms of getting those folks together who need to get together in communities so that resources can be more adequately used to meet the end of serving kids.

The question I have that you might want to comment on is a political one, in terms of ownership of the problem and the fact that children's aid societies are seen to service the poor in our communities more than the more-well-off who access mental health centres. Because of that, they do not get the high priority, perhaps, in terms of funding that they should. That is a problem you might want to comment on. It was raised this morning.

Mr Rivers: I would just like to speak to who our clients are, because your comments are quite accurate. The problem is that the most disadvantaged in our society, close to 60% of the parents we deal with, are single women. More than 50% of them are on welfare and about 48% live in public housing. All that constitutes the highest risk in our society, and we have been arguing long and strong to focus on those most in need. I think Dr Offord's comments previous to ours indicated that is one of the strategies that has to be undertaken.

Mrs McConville: I think your comment was very much worth making, because I do think this is a disenfranchised group of kids. There is no community owner-

nip of their plight and the child welfare system ends up being their advocate and that is not good enough.

There is another element here that we try to get at in the presentation; that is, that we are not very good yet in terms of identifying those interventions that work with certain populations of kids. Of course, we have a population of very disturbed kids with a whole spectrum of difficulties. So I think there is another real resistance on the part of our most specialized institutions that has to do with the level of disturbance of the kids we are having to place. We now for a fact in child welfare that our most disturbed kids are far more often being taken care of by everything out of the children's mental health system, because it cannot cope with it.

The Vice-Chair: We have run out of time. I thank you for your presentation.

Members of the committee, I think it is appropriate to take a five-minute break at this point, a seventh-inning stretch. We will reconvene at 3 pm.

The committee recessed at 1455.

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ONTARIO TEACHERS' FEDERATION

The Vice-Chair: We have before us the Ontario Teachers' Federation: Guill Archambault, president; Margaret Wilson, secretary-treasurer; and Ruth Baumann is here as well. Welcome to the committee and please proceed with your presentation. You have half an hour—the usual refrain. I have been repeating myself over and over again, but we are pressed for time so I hope you appreciate that.

Mr Archambault: The Ontario Teachers' Federation is pleased to have the opportunity to discuss with the committee today its concerns about the availability and co-ordination of children's mental health services in Ontario. As you know, OTF represents over 125,000 teachers in the publicly funded schools in the province and we provide education for almost two million students.

As teachers in the schools of Ontario, we have the opportunity both to witness first hand the increasing difficulties of children within our society and to be a part of the response to their needs.

The average child spends between 15,000 and 16,000 hours in school. Teachers spend more time with children than doctors, social workers, nurses or other service providers. For a significant number of children, more waking time is spent in school on a daily basis than with their parents and families. While teachers are not trained mental health professionals, the teaching profession must be an integral part of the delivery system for children's mental health.

School is an environment in which the ability to relate to others and a healthy self-concept are critical to successful learning. For some children, it is the first arena in which expectations for behaviour and outcomes are set by non-family members and in which they must learn to relate to the multiple needs and desires of a group. We would like to examine briefly some issues which we believe are

related to the state of children's mental health in Ontario and to any discussion of the delivery system.

Let's talk about incidents of violent school behaviour. The Ontario Teachers' Federation, working with its five affiliated bodies, has conducted a provincial survey of the incidence of assault on teachers by pupils in Ontario schools. For those affiliates reporting, there was at least a doubling of major incidents of assaults by pupils over two school years. We define major incidents as assault with a weapon, threatening with a weapon, serious physical injury, serious verbal threats re teachers' physical safety, and constant bullying. Minor incidents were described as punching, scratching, biting, pushing, insubordination and serious verbal abuse. Minor incidents also increased dramatically. Many of the very serious incidents reported involved children as young as six years of age.

Comments provided by the schools indicated frequent frustration in the ability of the school to have the problem behaviour taken seriously by parents, social service providers and the justice system.

The relationship between school and mental health services: the present gap between educators and providers of mental health services exacerbates the difficulties experienced by children. While some school personnel may be involved in referral, the provision of mental health services is usually at another location and often does not involve the school community in the treatment plan. The school in turn defines problems in educational or disciplinary terms, partly because of its limited ability to access other resources on behalf of students.

When Ontario's special education legislation was developed, a deliberate decision was made to use an educational model rather than a medical model. This meant that for students whose acting-out behaviour required special intervention, the focus was not to name the psychiatric disorder but to identify the unacceptable learning-classroom behaviour and build an educational program which would attempt to modify that behaviour in a positive way. There are times, however, when the difficulties are rooted outside the school environment and the school is unable to do more than address the student's needs within the school itself.

Teachers are often uncomfortable dealing with students whose behaviour is unusual or threatening because they have not had any training in doing so and feel isolated in their attempts to intervene. In those facilities where education programs are funded under section 27 of the general legislative grants, there is often interdisciplinary co-operation between educators, health care providers and social services personnel that allows an integrated approach and the opportunity to share strategies and resources. More active collaboration between the professions on an ongoing basis in the community school would do much to enhance both the skills and the understanding of the various professions involved.

Confidentiality is an issue that frequently touches the school. Many parents are reluctant to identify their children's mental health needs to the school for fear that the child will be labelled. The lack of an ongoing interdisciplinary approach to the needs of children in the school in

turn makes the negative effects of sharing information more likely. However, it also puts children at risk.

Consider the case of an adolescent with a history of suicide attempts and subsequent hospitalization and treatment who is enrolled in a large secondary school for the first time. The parents instruct the health care providers not to share any information with the school because they are concerned about the stigma. Without any information about the student's history or the source of the anxieties, it is impossible for the school to respond to his or her individual needs at all.

The balance between the need to know and the right to privacy can be maintained much more effectively if the working relationships among and between the various professionals are sound and trusting. A further advantage of ongoing collaborative relationships among the professional communities would be that the improved working climate would be of general benefit to the mental health of children in classrooms and not just to those who have been identified.

Then we have the changing family context. As the one social institution that touches all children, the school has been left with the major responsibility for coping with the changes in family life which society has experienced over the past 20 years. The majority of child care centres are now located in schools and more and more school systems have recognized the need for some kind of before- and after-school programming for school-age children of working parents. Unfortunately, while services offered under the Day Nurseries Act for young children are subject to clear standards, those services provided for school-age children are only occasionally provided under the auspices of the Day Nurseries Act and are widely variant in the quality of programming, staffing ratios and available resources. Many children are on their own before and after school for significant stretches of time.

1510

Beyond the number of changes in the number of working parents and single parents, another significant change in the family context is the loss of the assumption by children of their unconditional acceptance by their families. The growing number of adolescents living on their own is testament both to their willingness to leave and to the willingness of some families to have them leave. Perceptions of student welfare within the community have shifted from a view of welfare as a last-resort solution to very difficult situations to a view of student welfare as the alternative of least resistance to family conflict. This too becomes a significant issue for the mental health of children. If the support of the family for the child is tenuous, what resources can teachers or health providers call on? We did not take time either to discuss the whole matter of family violence, sexual abuse and all that.

It is time for government to make clear statements regarding our collective expectations of families and the support required by children and adolescents and to support these expectations with a service network and an infrastructure that meets the needs of Ontario families.

We will not reiterate some statistics, but I quote from Children First, the Report of the Advisory Committee on Children's Services. They say:

"We therefore believe that it is in the best interest of children to maintain them within their school wherever possible. The system must minimize the disruption that comes from removing children from their classrooms or schools as a result of disruptive behaviours, exceptional needs or required interventions from young offender, child welfare, or treatment services. To enable the school to accomplish its significant tasks, teachers must receive the required resources to enable them to maintain the child within the classroom."

In conclusion, the Ontario Teachers' Federation shares the grave concerns expressed by the Ontario Association of Children's Mental Health Centres regarding the need of Ontario children and the state of the mental health delivery system for those children.

When children are experiencing difficulties, there is a need for rapid access to appropriate services. Teachers and schools frequently find themselves attempting to manage and serve children with mental health problems without access to appropriate mental health and social service resources. There is a need for much greater collaboration between the mental health and social service providers and the education system in order to meet the needs of children. Ongoing collaboration and in-service for educators can strengthen the support network available and enhance preventive efforts.

Any discussion of children's mental health must also include a discussion of the environment in which our children live. Access to appropriate child care, access to protective services and access for families to a fundamental economic entitlement are necessary for a climate in which mental health is achievable.

As educators who care deeply about the children we teach, the Ontario Teachers' Federation declares its interest in being a partner in the provision of a healthy learning and living environment for children.

Mrs Witmer: On page 6 you make reference to the fact that the majority of child care centres are now located in the schools. I was wondering what type of data you have to support that. I was rather surprised to see that statement.

Mrs Baumann: I think that came from Children First. If you give me a moment I will try to track it down.

Mrs Witmer: I know that there are many child care centres in schools but I was not aware of the fact that the majority of them are now located there.

Mrs Baumann: They are not operated by schools, but the statement that I believe is in here, and I will try to pin down, is that the majority of child care centres are operated by non-profit operators within school buildings in Ontario.

Mrs Witmer: I appreciate that clarification.

Mrs McLeod: You indicate on page 5 that teachers are often uncomfortable because of lack of training and feeling isolated when dealing with students whose behaviour is unusual or threatening, and I can appreciate that

entiment. Would you say that is true even for children with the supposedly mild or moderate behaviour problems that are, in the current designation, seen as being within the mandate of the education system to deal with, as well as the more perhaps seriously troubled children?

Mrs Baumann: I think there are a lot of students who are falling under the rubric that we have assumed would be mild who in fact are kids with quite serious difficulties, but because the education system, in identifying those youngsters, really has limited access—and if you go back and look at the specific process the schools use through the identification, placement and review process, it is board personnel who by and large do the assessment of the child.

It is quite possible to have the youngster who may be experiencing even more serious difficulties outside of some get through that system and be identified on the basis of what appeared to be in-school difficulties with an in-school solution and to miss the kind of cross-referencing that probably should be occurring, either to health care providers or social service providers.

Mrs Wilson: We were surprised at the survey results because, particularly in the elementary panel, they identified quite clearly that a large part of the increase in incidents which were serious enough to concern teachers were tied to children who had been labelled behavioural. Normally the assumptions that we would have made are the assumptions you are making, that the disorders would be minor and that the teacher would be able to cope.

We are going to go back and try to pin down exactly what is happening. We asked the schools to identify over a period of time how things had changed and we are startled at the change over a short period of time and that they could identify the children who were involved in saying they had been through the IPRC system. Something is askew and we are quite sure, regardless of what we go back and find out, that there is inadequate assistance being given to both the children and the teachers.

Mrs Baumann: I think the one other comment I would make about that may tie into some comments that were made by the previous presenters. The spaces that are available for students who are not in the normal behavioural program within the special education context in the school system are spaces that are in mental health facilities, so if there are youngsters who have not been able to access spaces in group homes or agencies which would have a school component, they are in the schools and where they end up is often in the behavioural programs.

Mrs McLeod: I was even looking beyond the children who would be IPRC, because there is a clearly identified problem of some sort that requires special assistance and identification and placement. I am looking at those children who would not even go that route, with whom the teachers are coping in a classroom. I guess in the work that I did briefly I had a sense that teachers were often frustrated because the root of some of the relatively mild discipline problems was in the home and they had no access to the home to deal with family stresses.

I also quite honestly found learning problems that were missed because kids were inaccurately picked up as just

mild discipline problems. That leads me to say that the direction of the Maloney report sounds as though it has a lot to recommend it, provided the resources can be put in place. They have been around long enough to see the school system has to take on a lot of new tasks without being given adequate resources. Are you worried about it?

Mrs Baumann: Yes.

Mrs Wilson: Yes.

Mr Malkowski: I was very impressed with your presentation. It had quite an impact. We are aware of the changing world and how quickly it changes. Those changes influence family life and then of course influence the educational system.

But we are wondering, on the management of daily problems, looking at the teacher-student ratio and the children who come from different backgrounds, from dysfunctional families, or refugees from other countries who have suffered abuse, how teachers can manage all those problems. I am also wondering, from your experiences with the availability of counselling services within the educational system, does there not seem to be enough staff support who can make the referrals to outside agencies?

1520

Mr Archambault: This is true. For a long time we have asked for more guidance at the elementary school and more guidance at the secondary school, because it is surely a lack of a number of personnel. There are not enough to go around.

Mrs Wilson: The regulations state that schools must have guidance personnel in the secondary schools. The regulations do not insist on guidance personnel in the elementary schools. In fact, it would be quite unusual to have any significant time allocated to guidance in the elementary schools. This is a serious problem, one that we have been addressing ourselves for years. It leaves the onus in terms of finding assistance for children to already overloaded teachers, vice-principals, principals—the vice-principal if there is one. In many of our elementary schools the principal is a principal-teacher and teaches as well.

As Lyn said, if we are going to try to improve things for children without putting one more load, another straw on the camel's back I guess, we have to look at the infrastructure in the educational part of the system as well to make sure there are people there who can make the connections. I will not even address myself to the guidance ratio in the secondary schools. It is not terrific.

Mr Malkowski: Do you feel that it is important to expand the guidance counselling services and that they should happen in the elementary schools? Do you think that will help to reduce the problems that would be then faced at a high school level, and maybe if we give the guidance at the elementary level it will provide the students with better coping skills?

Mr Archambault: We have been asking for guidance personnel at the elementary school for some years now, and even though guidance personnel are added to the elementary school, I think we will have to put some more guidance counsellors into the secondary schools also.

Mr Jackson: I want to build on Mr Malkowski's questions. It was the area I wanted to get into. First of all, let me say that I have asked that the recommendations in two reports of the select education committee be shared with this committee, since you are now the fifth presenter who has been before both committees on similar themes. The numbers just seemed to get worse since last year when you were before us. Those recommendations contain areas that deal with education specifically and guidance generally.

I have a concern and I would like you to react to it. We have not been fair to the OSIS document, which I know calls for more guidance support but we are not providing it. I want to ask you to react as line professionals who comment on education but are impacted by educational decisions by trustees. Trustees will be up in a moment and you will be able to talk to them. They sometimes make policy decisions based on ministry direction and what is in vogue or what is the going thing. They also protect certain program areas, such as French language, which we know is coming at great expense—immersion, I should say—and yet we are not getting this priority for children's behavioural problems.

I want to ask you a couple of very specific questions—Margaret perhaps from her OSSTF background—with respect to the OSIS document and proper supports, and perhaps a general question about whether the ministry should be giving more specific guidelines with respect to boards that are protecting some program over another program. Obviously these children are not learning, and therefore, in protecting one set of programs, the will of the board might not be as appropriate as supporting these kinds of linkage programs for outside agency support.

I should tell you that earlier today we received a report about a specific board which has withdrawn to a degree some of its personalized support services. This is not the general guidance, this is the personalized support services. I am sorry, I am getting into a delicate area here.

Mrs Wilson: I think I should clarify one thing for the committee. I was on the steering committee of the secondary education review project, which was the mother or father of OSIS. That really is what Cam is referring to. One of the recommendations that that project made when it was dealing with essentially grade 7 through what was then grade 13 was that there be a significant improvement in guidance services. I think part of the focus of that report was on trying to improve career guidance services, because that committee felt that guidance services had drifted almost entirely to personal counselling. I want to make that clear.

That report also suggested that there should be—I feel as if I am here reinventing the wheel—better integration and that in fact some of the personal counselling services should be provided in the school setting by other agencies and that the school guidance department should be able to tap with ease into other agencies that would go into a school facility and provide assistance to students. I think when some school boards are in part withdrawing right now, they are looking at limited money and saying that

other agencies should be doing this, but we do not have an infrastructure that enables us to interconnect with them.

At the same time, when we were working on that project, what was absolutely evident was that a number of what secondary school people would call problems that we had identified were problems that did not begin when the kid hit grade 9. They in fact were sometimes learning problems, sometimes family problems, sometimes personal psychological problems, and they required assistance very early in the child's educational career since it was the school that was the venue where they had been identified.

I think even then all of us felt very strongly that the whole area of guidance, to a mild degree career and to a large degree personal, in the elementary school needed a really serious examination and that also in the elementary school we had to develop an infrastructure that brought the expert outside professionals into the school and into a better interplay with teachers who know about teaching reading but might not be trained in how to overcome, let's say, an emotional disorder that is preventing a kid from learning how to read, which is possible, and might not know what is happening in a child's family that is creating the blockage.

I was very happy when I heard that this committee was going to look at that particular area, but this is, I hope, the end of a long debate in Ontario about how we proceed on this.

The Vice-Chair: I have Mr Beer next for a very brief question. We are quickly running out of time for this segment.

Mr Beer: Because we are running out of time, I would simply say that the last comment, Margaret, that you make is critical, that this is the beginning of a public discussion.

When I look at the Children First document, which provides the basis for a very meaningful and necessary debate but we know raises a lot of issues around structures. I think that the question we cannot go into fully here is how exactly, if the school is to be the hub, it is to be the hub, and what the role of individual classroom teachers and principals as they interface with the other sections of the children's services sector is.

I would take it from that last comment that, if there is a recommendation that somehow helps the government go on with more focused public discussion over a reasonably short period of time, that is very necessary in your view so that the educational world can have a clearer idea of what would be expected from it in any major changes as to how we deal with children's mental health.

Mrs Baumann: I think it would be safe to say that we would like to see a lot of discussion about how to integrate those services. We have tried to say in the submission that you have today that we think the case has been made for a long, long time about the fact that they need to be integrated and that we no longer need to talk about the need for integration but the mechanisms.

Mr Archambault: I would like to have a few seconds to respond to Cam's second question on the protection of some programs. I think the trustees do whatever they can

with the funding that they get and in the last few years other programs have been coming in without additional funding so we can see why some programs are being protected at the expense of others and it becomes a political choice for them.

The Vice-Chair: Thank you for your presentation.

[Later]

The Vice-Chair: Members of the committee, I have a request by the Ontario Teachers' Federation to make a correction. I will read it into the record:

"The statement on page 6 of the submission of the Ontario Teachers' Federation to the standing committee on social development which reads, 'The majority of child care centres is now located in schools' is an error and should read 'According to Children First, one third of all child care centres are now located in schools.' The Ontario Teachers' Federation would like to apologize for the error."

1530

WATERLOO COUNTY BOARD OF EDUCATION

The Vice-Chair: We will move quickly to our next set of presenters, the Waterloo County Board of Education, represented here today by Susan Sanderson and Bill Otto, respectively the chairperson and the vice-chairperson, and anyone else who I am not aware of may identify themselves. Please begin, and welcome to the committee.

Mrs Sanderson: Thank you, Chairperson, members of the standing committee. We welcome this opportunity on behalf of the Waterloo County Board of Education to share some of our experiences and perceptions with regard to mental health services for children that are provided within the region of Waterloo and across the province of Ontario.

I would like to take this opportunity to introduce to you the people who have accompanied me this afternoon. Mr Otto, our vice-chairperson, is in the audience. John Monteith is to my right. He is a trustee and as well chairperson of the special education advisory committee. This, as you may know, is a legislated committee comprised of community members with an interest in special education. Dr Steve Chris is also in the audience. He is co-ordinator of student services and a psychologist with our board. Vic Graham, also in the audience, is executive officer with the chairperson's and director's office, and on my left is Gord Backenhauer, superintendent of special education with our board. I extend regrets from our director, Ray Ward, who is unable to be here today because of illness.

I would like to refer you to the document before you and spend a few moments to highlight some specific concepts that form the base for the recommendations that we shall put before you, and at the conclusion we will be pleased to entertain questions.

If we turn to the first page, the first part of our presentation is simply background on public education within Waterloo county.

"Co-operative working relationships—past and present:

"The Waterloo County Board of Education has a long tradition of working co-operatively with the local agencies

within our community. However, because of individual mandates and budget restrictions, 'territoriality' is sometimes seen as a factor in creating gaps in service delivery for students with social, emotional and behavioural needs.

"Schools have assumed an ever-expanding responsibility to respond to a broadened range of needs of children, regardless of exceptionality....As we have worked on studying student needs and taking a look at gaps in service delivery, we can see that good interagency resource interaction can best provide for the needs of students. We can also see that the school can be a focus for service delivery models that are initiated from the multi-agency viewpoint. This does not, however, negate the needs for the provision of existing services by hospitals, treatment centres, children's aid societies and others."

Under "Directions for integrated service delivery," the Graham report does promote an integrated, collaborative approach to planning and service delivery.

On to page 3, "The school as the focus:

"The school system must be a key partner in the development, implementation and evaluation of service delivery models....There must be a commitment at the provincial as well as the local level to use existing and expanded budgets in a flexible way to design and implement co-operative ventures."

Pursuing the funding, "There will still be a need for the availability of additional designated funding by each of the ministries to meet the broad range of children's mental health needs."

Under "Summary," we say:

"If agencies are to work co-operatively as a multi-faceted response mechanism, then they must have the mandate to do so and must be accountable in a way that will provide consumers, family members and the service units themselves an opportunity to help to plan, implement and evaluate what is happening. Funding must then, by mandate or by legislation, if necessary, facilitate these directions."

In our "Specific Recommendations," we say:

"The partners, especially Education, Health, Community and Social Services and Corrections, should be mandated, both provincially and locally to legislate the development of 'Children's Services Planning/Advisory Authorities' to assist in the co-ordination of children's services at the local and provincial levels; to work co-operatively in planning for and implementing changes and new directions; to fund services that are planned co-operatively; to enable schools to become a central focus for inter-agency needs assessments and service delivery; to support a continuum of services by the ministries of Education, Community and Social Services, Health and Corrections."

Once again, we thank you for the opportunity to be here today.

The Vice-Chair: We have a fairly lengthy period for questions, so I will be begin with Mrs Witmer, and there are several others on the list.

Mrs Witmer: I would certainly like to extend my appreciation to the staff and the board. Having been a former trustee on that board, it is a pleasure to know that the

presentations are still excellent and that once again a tremendous amount of research has gone into your presentation. I guess the one thing I personally appreciate are the very specific recommendations that you have made to this committee. That is certainly something that we were looking for.

You talk in this report about co-operation, the need to work with all of the ministries, the need to work with local agencies. I wonder if you can give us a little more information about the joint early identification/early intervention school-based program that has been initiated in your school board area.

Mrs Sanderson: Thank you, Mrs Witmer. I would turn that over to Mr Backenhauer, who certainly has been instrumental in that program.

Mr Backenhauer: For the last couple of years we have been involved with the ministries of Community and Social Services and Health and the separate school board in a joint venture, taking a look at children at the kindergarten to grade 3 level who are exhibiting behavioural, emotional and social needs within some of the schools within our county.

We were able, through that joint effort, to develop a co-operation among those four bodies and, ultimately, in getting resources from the boards of education, getting extended resources from Health in the form of public health nurse involvement in expanded school-based teams and actually receiving a dollar allotment from the Ministry of Community and Social Services to hire intervention workers in the schools, we were able to begin the project. It is under way at present time. We are going to build in an evaluative process to it. We are going to call it program evaluation, as opposed to research, because feel that we want to know what is going on in the program. Hopefully, it will emphasize the co-operative nature that has happened among the four agencies and the community.

I will tell you up front that when we began that there was a lot of territoriality and people were saying, "What can I bring to this and what can I get out of it?" I think we have come a long way, as we need to, in the whole attitudinal direction in working together. I guess I would use that as a last point to state that if there is to be a mandate that should come from the provincial government, it should be two agencies to have the mandate to work together in order to provide this type of co-operative venture. I may get an opportunity to expand upon that.

Ms Haeck: I really do appreciate your being here today because you allow me to put forward a question centred around a particular project that our Lincoln County Board of Education would like to put forward. I think it is very innovative because ultimately what it will end up seeing result is that teenage mothers are able to have their children looked after while they are also in school.

My question centres around the funding issue, because in fact the regional municipality of Niagara will be funding the day care component. How do you see yourselves, or school boards in general, working with regional governments on issues like this? Basically, it is a primary preventive area.

1540

Mr Backenhauer: If I may respond to that, as we suggested in our recommendations to you, and I think this would apply to Lincoln county as well, I think the provincial government has to mandate local agencies to work together. I guess when you take it to the local base, you have to give some degree of flexibility for local people to meet local needs, whatever those needs are, and to deal with issues such as the one you are talking about.

I would suggest that the mandate should come down to existing political and staff bodies that presently exist within regions at this time to put that forward as an issue and then to say to those people, "Can you develop a structure that will satisfy the needs within your own community to do that?"

One of the second points is that if you are going to do that, there has to be some flexibility in the ability to fund, and that then may mean that additional dollars, at least in the interim, have to flow provincially and might be earmarked, but along with that, a direction within that mandate to say, "You need to work together in order to provide those types of directions."

Mr Beer: I would just note, Christel, there is a project like that which the York Region Board of Education and the region of York and the province have started that sounds very similar. It is a pilot project but one that we have a lot of hope for.

I wonder if I could ask you one of the questions around governance and structure that arises from the Children First report. You are, I think, our first board of education and I know you will not have had a chance as a board to discuss it, but perhaps just some of your preliminary thoughts. I should note that we were chatting earlier about this, but I think it would be useful for the committee.

In the Children First report there was a suggestion that there be some kind of elected body that would be looking at the provision of children's services. We have had the structure of the school boards in the way that we have had them for some time, and I think the purpose of its being in the report was not so much that this is the only way to go, but to try to get a public discussion going about how are we delivering children's services at the local level, where we have one institution, the school board, which is very large and has a large budget and a large mandate, and then a whole series of other people who are busily at work and whose work takes them into the schools, or certainly working with the kids who are in the schools.

As we go forward with this, I notice in your presentation to us you talked at the end, under "Specific Recommendations," about having these children's services planning advisory authorities to assist in the co-ordination. Do you think we can do it that way or is there a sense that we are going to have to have a body with some sort of power, in effect—some elected clout, if you like—in order to make the kinds of changes that are going to deal with the problems that everybody has been describing for us? What are some of your initial thoughts on that?

Mr Monteith: I can speak to that. Initially I have a bit of difficulty with the concept of an elected body at the

local level dealing with this, the reason being that if this is going to work, it is the workers in the field who have to co-operate and collaborate to make it effective.

I would rather see a structure somewhat parallel, if you like, to the way special education advisory committees are structured, where various agencies in the community appoint and elect—delegates elect—individuals to act on a committee. This way, I think we would tend to get people who have interests in the specific areas that they represent rather than leaving it to chance that the various interests would be represented through a general election.

I think also it would encourage appointment of perhaps staff personnel to act on this committee who are the people who ultimately have to work together in the end anyway. I now I worked for a number of years in a situation, in a provincial institution, where Community and Social Services and Education not only worked together but within that, the disciplines worked together. I worked at Midwestern Regional Centre and under that structure we had psychology, we had medicine, we had the chaplaincy, recreation, residential setting, social workers, teachers, all working together on committees at case conferences for the children's mental health care and at other sessions related to their needs. That was very effective. The people who were working with the individuals worked together in the planning, worked together in developing the procedures and so on, and it was exceptionally effective. I would like to see that same type of situation applied to what we are talking about here.

Mr Beer: If we were to follow that sort of outline, that kind of children's advisory group or council or however called, ought it to have some authority or power over the allocation of dollars, whether they came from Education, Comsoc, Health, Recreation? I am trying to get a sense at the local level of how much authority we want to vest and how much accountability in a new structure we might put here. Again, I am not going to quote you a year from now, but we need some direction.

Mr McLeod: Hansard will, though.

Mr Backenhauer: I think within Waterloo county we have met on an ongoing basis, and we did last Friday morning as a matter of fact, at the latest with people representing Health, children's aid societies, some of the treatment agencies and so on. One of the questions that comes up is exactly the one that you raise. I think that people see local political structures—eg, the district health council, the social resources council, the boards of education—as having a political mandate, if they get together, to be able to direct these services.

We have talked about the funding aspect of it. I think there is a twofold opinion on that. One is that if you give dollars to an advisory body of that nature, then it gives it more clout and consequently it will be able to direct. There are other people from other agencies, at our level at least, who are saying, "Hey, we don't want that because that takes away from the planning advisory aspect of it."

I think it is something that is going to have to be weighed very carefully. Just to put in a plug for Waterloo county, I think we are just about ready to take the next step

if those political bodies were given the mandate to do so. I think we would be able to take the next step and it would be interesting, as a pilot direction at least, to say what would happen if some degree of funding were given to that group in a co-operative planning way, for example our early identification/early intervention type of program and saying, "You have a mandate to begin." We will carry out a program evaluation and we will then have a responsibility to report back to whomever to say, "Does that type of co-operation really work?" We think it will.

Mr Monteith: Just to add to that, while there may be funds necessary, I think the other thing happens when you get people who actually work with the children working together in a model. But I suggest that my previous experience was that, where it was determined that a particular discipline should provide a particular activity, service, whatever, to an individual—for instance if it was decided that I as the educator should perform a certain service and needed a certain piece of equipment, if during the course of the case conference I said, "Well, yes, I agree completely but I don't have the money for the equipment," it was very common for someone from the other ministry to say: "Look, I have a few extra bucks in my budget. I can spring for it this time." Next year it might be the other way around. There tended to be a sharing of budget across this fund and even between a few ministries in that setting. I think with the extra funding, plus getting people working together at the root level, money is spent more efficiently as well.

Mr Hope: As we are seeing the indication in school boards and your interest in getting involved, and I am proud that you are, in voicing your concerns about the children, because yes, you do spend a lot of time with our children as we have shift workers who have seen what is going on with the economic stages. But I guess my question pertains to the time frame between when that child is born and he enters the school system.

I have heard the reference of the school board being the hub of the situation, and I am now wondering if we are not trying to put a Band-Aid on the sore after the sore has been there, wondering about that time period when we should be addressing the need, when we can develop the change. Are we going to devise two mechanisms now, an earlier stage between the birth and entering the school system, and then we are going to have another system after? I guess that is the question: How do we get to them at the earlier stage, when we can get to the parent and get to straightening out the problems initially, not waiting till later on?

1550

Mr Backenhauer: I think you can have two systems as long as the systems work together and communicate with each other as to what is going on. As an example, one of the directions that is going to be taken by regional health and public health nurses is taking a look at the three- to four-year-olds who are in our region at this time and those who exhibit needs, and then very carefully building up communication directions to us in the education system so we know before the youngster comes into

the situation some things that have been tried, some directions that have been taken, so we can be in that dialogue process before the child actually comes into school.

Another thing in our early identification, early intervention program is that the hours of the workers who have been assigned are going to be extremely flexible, because some parents are not available during the day, particularly single moms who are working. We are setting up a system where meetings take place in the home at the times when parents are available, and even reinforcing the fact of recreation opportunities and that meetings might take place in a town house grouping and so on. These types of things need to be brought together, and only through the type of planning advisory body we are talking about do I think all of those things could come into some type of focus.

Mr Hope: We have already indicated the category of people in need of this service; we have labelled these people as welfare people. I imagine there are some here who have had a few years of service in the school system. Has the school system, in its calculations—is there a differential between the time frame of the early 1980s, when a recessionary period was on, and the time frame we are dealing with now, those two time frames? Are we maybe missing something in our education system and are not fully informing our younger adults—I am talking from grade 9 to grade 12 or whatever—about the real facts of life, that everything may not be peaches and cream and coping with the realities of what may happen? Have we even done a study between those time frames, between the recessionary time of the early 1980s to the recessionary time now?

Mr Monteith: I will take a shot at part of what I think you are asking. One of the situations you run into with time frames is not necessarily preparing children for the reality of the situation they are going to face when they get out there, but dealing with the reality of now, especially now with the freedom of information act in fact protecting a lot of information—and even before with the degree of confidentiality that existed and so on.

In the past, quite often what would happen is we would get an agency dealing with a child on some particular aspect. The child could have benefited from a multiagency approach in that the child had other needs, but somewhere down the road, because the child has only received support in a particular area, all hell breaks loose and all of a sudden somebody else says: "Look, why didn't you call me five years ago or three years ago? I could have done something. It's too late now."

If we are concerned about time and the time factor, I think it is even more important that we get these agencies together under some form of mandate or legislation, because, if I remember the freedom of information act, one section provides that where a body is mandated or legislated—I forget the exact wording—they can then share information. If we get working with these children, getting all the agencies that need to be involved, at an early enough age to develop appropriate attitudes towards education, appropriate mental health, appropriate attitudes towards life, the children can then benefit from education

relating to changing times and the things that schools are trying to do.

Too often what happens is that you get a situation like the early 1980s, where a child has a problem and one agency deals with it. We get into better times, and because times are better the problem diminishes. We hit another recession and boom: because the problem has never been solved it is now major.

Mr Jackson: I would like to concur with Mr Monteith's observation about the elected board. I have not dwelled on that issue, but I have a real concern about people competing to be elected to that board. Even Colin Maloney made brief reference to its relationship to something that is happening in the Ministry of Health, which is the whole elected nature and shift of accountability with respect to district health councils, which also deal with children's mental health services and delivery mechanisms. We have not even got into this whole conflict that exists between those two bodies and government policy in those areas. I, for one, would not abide any system which sets up a blockage between the kids who need the service and us here at Queen's Park. In other words, we have some board we can offer it to and say, "Will you set the priorities in Waterloo county and you iron it out and argue with the people in Waterloo and then come to Queen's Park and prioritize your 10 needs down to 2?" I am really not interested in developing systems like that in this province. You are spot on, and I commend you for being so clear on it.

My question has to do with the select committee on education reports and concern for transfer of funding. We have heard from every group about funding. We have heard from everyone about financial incentives to get off projects and move into consistent program delivery. For that reason, the Tories and the NDP have strongly objected to the move to take special education funding and roll it into general grant. This has a devastating effect in terms of accountability from us at the province to school boards in terms of special education delivery. We recommended in the select education report that that system be stopped and that we go back to identified special education funding, as well as tearing down the elementary and secondary funding panels which we have had traditionally. That recommendation is outstanding. We have heard nothing from the new government. Would you recommend to this committee that we reinstate that so we have at least an accountability mechanism for special education funding instead of, on bended knee, competing for these pilot projects that everybody loves but we know we are not going to get the funding for—even the successful ones may not get the funding? That is not a leading question. Take that anywhere you would like to take it.

The Vice-Chair: I would like to leave time for a response, Mr Jackson.

Mr Jackson: A yes answer is what I am looking for.

Mr Monteith: And that was my answer. I cannot be any briefer. Yes.

The Vice-Chair: You have put it clearly on the record. We have run out of time, unfortunately. I would

ke to thank you for your presentation. Obviously, it stimulated a great deal of discussion, but we will have to move on.

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ONTARIO PUBLIC SCHOOL BOARDS' ASSOCIATION

The Vice-Chair: We must move on, pressing ahead with our next group of presenters, the Ontario Public School Boards' Association. I call upon Ruth Lafarga, past president, Penny Moss, executive director; Rhea Springsted, I am informed, is also here. Welcome to the committee. As I try to impress upon all the presenters, we have a strict limit of half an hour for your presentation. You may divide it in whatever way you deem most appropriate.

Mrs Lafarga: Thank you very much. I am very pleased that you made time for us today. We really do appreciate the opportunity to present.

The Ontario Public School Boards' Association represents 94 public school boards in the province and some 1.5 million students, the majority of whom are very healthy, well-adjusted students, and I think we should keep that in mind. Nevertheless, our concern is for those students who need some extra help.

Our presentation reflects very much the presentation we made to the Advisory Committee on Children's Services. We do not have a set of recommendations or really a magic way in which we can address the changing needs of vulnerable children. We do not have any structures for the delivery of services, but we do want to focus on the concern. I am sure you are very familiar with some of the statistics of the Ontario Child Health Study, which has identified that some 40,000 children are identified with antisocial behaviour. In listening to the previous presentations, I would like to reinforce what we hear in the school system, that that is increasing at quite an alarming rate. I think the reasons for that are very complex. You cannot point a single finger at them, but nevertheless they are causing a great deal of concern in the school system.

It is also true that the traits we find in antisocial children are more often identified in needy children and those who are poorly housed and nourished, children of single parents and parents who have ineffective parenting skills. The superintendent of special services with our board stated that he believes we are starting to see an underclass—the same term which has been used for a lot of years in the United States—that is more or less perpetuating itself with problems.

I think what we see in the school system is that in the early years children come into the school system, whether it be junior kindergarten or kindergarten, with irritability, discipline problems, inattentiveness. That is a forerunner to low academic achievement, because they have low academic preparedness, they are just not ready.

Over the years, you discuss this with teachers and they increasingly tell you about the sorts of students they are trying to deal with. In the mid-years, with many of the same students, we see they become aggressive and disruptive. Quite often, they are rejected by their peers. Oft-

times, they are rejected by their parents. They are possibly rejected by their teachers, because they are the problem-makers. We are all very familiar with that. Or they may be excessively compliant and withdrawn from their peers, too, and create problems in terms of their achievement from that. Whatever the manifestation, it results in poor school achievement. Then, of course, in adolescence we see this further alienation from the mainstream and they withdraw from their peers and eventually get in with what we call the wrong group and we see adolescent delinquency forming.

Through all of these various stages, of course, they cause problems for adults and ultimately for their own quality of life, which is lowered as a result of these problems. They have problems with relationships. They have problems with academic performance and, ultimately, psychosocial problems with alcohol, drug abuse, criminality and poor parenting skills, so the cycle is repeated.

Many of the programs currently in place address adult mental health problems. They are expensive and there has been very little success with those various problems. What we would like to see is that the intervention and prevention should be in the early years for these children, with the focus particularly in the school system.

One of the things we have to realize is that the school is the only common element in all children's lives. It is a safe haven for many children. In some of our schools, you will find that some children are reluctant to go on overnight excursions because they are not sure what the home life will be when they return there. This is the extreme for many children, of course, but this is a reality for them. I think the focus of the school cannot be overestimated. It is the common area for them.

For the majority of students, it is compulsory for them to be there from 6 to 16, except those who go through our SALEP committees, supervised alternative learning for excused pupils. Where we have JK and where we have day cares in our schools, that is lowered. What teachers ask is: "How do we teach children who come to our schools angry, hostile, ill-fed, ill-clothed and distressed by what is happening in their personal life?" They are indeed very vulnerable children.

When we have other agencies we have the problem of the lack of services available and the lack of resources within the school system. I have heard some of the questions earlier, and I think, too, there is still an ongoing debate in some boards about the extent to which the school system should have to pick up this problem. But in many boards they have done it because they recognize the children simply cannot be taught if in fact they have all these social problems. We have to deal with the social problem. You cannot attempt to teach a child who is very, very unhappy.

In our presentation you will see a list of programs—as usual, I never have the presentation quite in front of me—on page 3 that are not universal to all boards but are examples of various programs that boards have moved into. It is not a complete list, because there are in some boards programs for pregnant teens; there are other programs we

are always introducing because we see the need. I think there is very much the recognition that the school system has to deal with these issues.

We make the point because we see that the problem is increasing and because we recognize, as I have mentioned, that the schools are the only thing common to all children. The setting is usually where the first identification is made for children when they come in for their early identification. This is where these social and emotional problems may be first identified.

Very often the parents, because of their own experiences, may not feel really that ready to come into a school setting. Nevertheless, with their child they will come in and through programs that have been made available, they can be helped with the parenting of their children. Schools, too, provide a setting for group intervention with many of these children; that is being tried in a number of areas across the province. If poor school performance contributes to increased antisocial behaviour, the deficit we hope can be remedied within the schools and, as I said, the parent concept of the school as a place that will help their child.

Obviously, you have heard over and over again about the need for improved availability of treatment services if prevention is to be successful. When I go into my own schools, which I do on a regular basis, and hear of the problems, what I am told, even in schools where we have social workers, is that there simply is not the availability of services for these children. Even when you identify the problem and know where you want to go, the services are simply overwhelmed. We need to improve the availability of the treatment services.

You have heard, too, and we want to reinforce, that the mandates re children's mental health through Comsoc, Health and Education have to be more closely defined and the policy level has to be addressed. We need to break down the territorial barriers between these areas. People working in this field are very, very frustrated about the talking about this that goes on. People say they have been working in this area for years and they keep talking about breaking down the barriers but it just does not happen.

I want to reiterate how important we think the work of this committee is and how hopeful we are that some positive results will come out of it, and to really emphasize that as the Ontario Public School Boards' Association we want to be involved in the discussions that take place, because so many of our boards are already working in this area.

1610

Mrs McLeod: I am in complete agreement about the importance of developing a more integrated co-ordinated approach and sympathetic to those who have expressed frustration at the number of times we have come close to trying to create a model and not been successful. I am going to direct my question very specifically to one of the toughest parts of implementation, following up on what Mr Beer asked the Waterloo county board. It may be premature to ask for a response, but I am going to raise the question quite specifically anyway.

The Maloney report suggests elected children's services bodies at a local level. The Waterloo county board, in responding to Mr Beer's question about structure described something which it thought would work which sounded like a much more modified version: a multiagency with professional staff, maybe community representatives, that would do the planning for programs with a centrally targeted funding from the province. At least I hope I am doing justice to the suggestion they made.

I would like to ask you whether you think there is room for something larger, for local authorities that would have global budgets which they would then have to allocate according to priority. If you think there is room for that, do you think it should be elected or not elected, and if not elected, should only school boards have access to the tax base? I am making the assumption that you cannot access the tax base without elected representation. How would school boards then determine what were traditional school activities that should be served with local tax dollars?

Mrs Lafarga: I am going to ask our executive director, Penny Moss. Give her the difficult questions.

Mrs Moss: So that I can say we do not have a position on it, and hopefully we will not. Maybe I can suggest why. I would like to hope at this point in time that the recommendation of the Maloney report plants a very big seed and says there are some serious issues of governance, accountability and funding that need to be resolved, and if we can accept that is what the report says, then look at how to do that.

I suspect that in an ideal world, being Ontario, the model that would be appropriate to ensure the needs of children are met may differ community to community. If that is the case, one other way of looking at this is to ask what range of services ought to be available to communities in Ontario if our desire is to raise healthy children, healthy in terms of school achievement, of mental health issues and physical health issues, social and emotional. What is the range of services, who is doing what and who is not doing what, and what are the provincial policy expectations for those services? At the local level, let lead jurisdictions that already exist, for example, have a bash at working out structures that would deliver those.

There are some quite wonderful examples. In Ontario, for example, there are municipalities that fund to the maximum infant child care spaces for the parents in high schools. There are other municipalities that refuse to make that a priority. In other words, teen parents in one jurisdiction have access to high-quality child care with parent support services and school and very similar teenagers somewhere else do not.

I think if we clarified the expectation of that service to be available, it helps at a local level if people say, "That is not within our mandate." I think what we want to do over the next little while is to work with key other partners in this area to start to define some of the models in ways that are sensitive to governance issues but that do not divert any more money than is necessary to the creation of more

management and bureaucratic structures when the cry everywhere is for direct services to children.

I think there is a longer-term agenda and an immediate short-term one, and can we use the short-term to develop the models for perhaps more long-term implication.

We cannot separate, as a last point, this policy discussion from the question of reforming education finance in terms of the need to define education's mandate, let alone everybody else's. I think it is an exciting time for the province but it is hard to imagine those big questions being dealt with in an either/or manner and not in an evolutionary manner.

Mrs McLeod: I guess I raised the questions because I am concerned that the conceptual model will break down when we get to the equalities or inequalities in the partnerships and the role of provincial versus local funding.

Mrs Moss: Could I just have one minute? To be really radical about it, what would happen? Local municipalities and local education are creatures of the province at this point in time. What would happen if government said to "de-elect" these bodies that they already have? "Tell us your plan for the delivering of this range of services and what might be the mandates and the provincial-local split." If they cannot do it, then perhaps it is that bigger solution. But the health care councils have not solved those problems themselves. That is possibly one of the models we have got. There are some models in the training area as well, but none of them actually do what Maloney asks to be done.

Mrs Lafarga: I would just like to add that there are a number of pilot programs, of course, now through Dr Offord that are taking place—I am sure you are aware of those—where you have, with local boards bringing in various agents, representatives of various groups. While they are just in their infancy, I think that the results of those pilot projects and the various ways that they work out in different areas of the province will give us a good handle on perhaps what the model should look like.

Mr Martin: It may be just a regurgitation of what we have just gone through; however, I would like to chase it a little further. I have given the history of the discussions between various agencies and bureaucracies that have grown up over the years in Education and Health and the Ministry of Community and Social Services. The suggestion that you have here, after speaking of the Children First report by Mr Maloney—he used a term that I like but none of us in North America, and particularly in my experience in Ontario, are very good at, and that is the building of consensus among all interested parties. Do you think that is possible?

Mrs Moss: I do, but I am an optimist—I do not know.

Mrs Lafarga: I think you have touched on something that is quite interesting, because I think it is a new mode of operation to build consensus. It is probably true that many of us do not have the skills in that particular area, so we do have to learn what consensus is and probably never more than we see in the world today. We realize the importance of that. I think we are starting to see people who have

these skills coming into leadership roles. I think that is something we have to continue to work at.

Mr Martin: I suggest to you, as you have suggested to us, that that will be key in any successful—

Mrs Lafarga: I recognize this is the problem and it has been tried before. I think there probably needs to be some direction from the government in terms of encouraging that, whether that be financial or in organization ways. But we do need some structure down because we are getting all the projects around but we need something to say—

Mr Martin: We used the term earlier, "levering," a little reminder to just sort of move it along a little bit.

Mrs Moss: Yes. That always helps, but while everybody says incentive funding and pilot projects to test out models in education, we have growing concern about the development of models in individual locations which in fact do not get transferred. The Ministry of Community and Social Services itself a few years ago engaged in quite an innovative program on the development of prevention models for high-risk children. Some of those were really innovative, but it is interesting to look now and see which of those projects still exist.

I do not know if I am quite up to date, but by and large, the ones that exist still are the ones that used prevention money, as it was called in those days, to develop models that would feed into the existing funding structures. Those who used the money for operations had a real problem if the government did not continue to fund them in an extraordinary mode. I think that has to be watched for.

Mrs Lafarga: Very often, that sort of funding comes away from your main funding and people become increasingly hostile about it. That is really a danger.

1620

Mrs Witmer: I certainly appreciated the opportunity to hear your very thoughtful and thought-provoking presentation. You made some reference to the Maloney report. What other recommendations do you feel are contained in that report that we should be pursuing and taking a look at?

Mrs Moss: It is new and it is out of print so our association has not had committees and suchlike look at it yet. My own view is that the section on entitlements raises some interesting questions about the possibility of creation of a model, if you like. This is our vision of entitlements for healthy children, healthy again in the broadest sense of what the implications of that are for the provision of services in local communities. I still maintain that they have different implications in different communities.

Mr Owens: One of the things we have not heard a lot about in the last couple of days is kids who are faced with multiple challenges, perhaps having a mental illness but as well being physically challenged or deaf. How are these kids identified and how are they serviced, or are they serviced, within the school system? The last paragraph in your "New Directions" section talks about wanting to make the school system a key partner in this process. I am just wondering how that process takes place now and how

the assessment is done. Do we lose kids as a result of the overlap of problems, and what kind of resources would you see yourselves, as persons involved in education, needing to carry out that kind of work?

Mrs Lafarga: Are you talking about multihandicapped children?

Mr Owens: Yes.

Mrs Lafarga: They are of course identified very early, the first six months, but they are in the school system and they are fairly well serviced by the school system, I believe. I do not see that the problem is with the multihandicapped children. I think in terms of our services for those children, we are spending quite large resources on them. I believe it is in terms of dealing with children with emotional problems that we are having more problem.

Mr Owens: That is what I am referring to, the overlap where a person has a physical disability of some description and also an emotional illness. How is that dealt with at this point?

Mrs Lafarga: I am not sure.

Mrs Moss: In a variety of ways. At the level of the school boards we do not have intimate knowledge of the individual circumstances and approaches, but I think it is fair to say in most jurisdictions the multiply handicapped children in school have, as Mrs Lafarga said, been identified really early, and it is in some respects people's experience that they find it easier to access further services for some families already well connected with the caring profession.

There is always an issue throughout Ontario about the size of local resources, so that you will find that the sophistication and variety of services available in some centres in schools is dramatically different than other communities. Some school boards still have managed to retain, for example, qualified child psychiatrists on staff. Other school systems have not been able to afford social workers or a child psychologist, so I say it is mixed. In some respects, access for kids already being served may be greater than the new entries to the system.

The Vice-Chair: Mr Hope for a brief question.

Mr Hope: Through today's presentations, and yesterday, it was indicated that a lot of the people who do not receive services are either going to end up becoming murderers or being thrown in jail. Hearing what you were expressing yourself today, you are saying most of them cause self-infliction of trying to commit suicide.

I just want some clarity, because we seem to be losing sight of it and I would just like to know. There are those who may attempt to commit suicide under frustrations, but the thought that may be being put out there is that if they do not get these services, they are either going to go to jail or commit suicide, and I just want some clarity on that.

Mrs Lafarga: I think we made the point that they will have behaviour that is socially not accepted, whether it is alcoholism or drug use or something like that. We are seeing more problems certainly with suicide attempts with young students as a result of various stresses in their lives, and I can attest to that.

I do not know if that is because that has become an issue we are learning more about or if that is the reason but there certainly are children who are very stressed and we have parents coming into the school system asking for help. In many cases, because the resources are not available in the community, the schools are very stressed and they find that they have to try to adapt their programming for the child and that they really need more experiential programming in other areas.

The Vice-Chair: Thank you for making your presentation.

Mrs Lafarga: I would just like to reiterate that we had to work with two partners in this process.

The Vice-Chair: We certainly appreciate the time you have taken to present before the committee.

EARLSCOURT CHILD AND FAMILY CENTRE

The Vice-Chair: We have, last but not least on our list, the Earlscourt Child and Family Centre. I would call on them and Kenneth Goldberg to make a presentation before us. Please identify yourselves for the purposes of Hansard.

Mr Goldberg: I am Kenneth Goldberg, executive director of Earlscourt Child and Family Centre. To my left is our distinguished past president of the board, Paul Schroeder. I am also pleased to indicate in the audience two members of our board, Jinni Morton and Jane Shapiro.

Earlscourt Child and Family Centre is a non-profit children's mental health centre serving predominantly the cities of Toronto and York and governed by a 16-member voluntary board of directors. We are committed to improving the life circumstances of aggressive children and their families. We believe that children and their families are affected by their social environments and that services must be client-driven and delivered in the context which is most relevant to them. We provide children and families opportunities to improve their life chances through services which are based on the most advanced psychosocial treatments.

Our goals are these: To provide effective programs for aggressive children, ages 6 to 12, and their families; to facilitate the development of social and self-control skills in the children and child management skills in their parents; to conduct evaluative research; to improve program delivery and enhance our understanding of childhood aggression, and to ensure that all staff receive the best possible training and appropriate supports.

We operate a range of programs that I will just describe very briefly to give you an idea of what is going on. Our residential treatment unit for eight children will serve about 20 children annually, for approximately 8 to 10 months, for mostly stabilization purposes. Our family services department serves about 80 families annually. Most of the interviews are conducted in children's homes after regular office hours. Treatment there lasts roughly 6 to 8 months and is delivered by a small department of four family workers, one of whom is Portuguese-speaking.

Our under-12 outreach project was established in 1985 in conjunction with the Metropolitan Toronto Police Force

response to the Young Offenders Act. This program serves about 70 children a year and offers a multifaceted program, including transformer clubs, where the children learn self-control and problem-solving skills; individual befriending, which is done by both professional staff and volunteers; tutors; parent education groups; family crisis intervention and school advocacy.

We operate a school-based program in St Paul's and St Martin's Catholic schools in the Regent Park area. This program involves teachers in classrooms, social skills instruction, identifying particularly aggressive children for specialized withdrawal groups, individual coaching and involving parents wherever possible. This program once served 16 schools. With underfunding it currently serves two. That will be a recurring theme.

630

Our school liaison programs at Huron Street, which is a contract program until the end of June, and at Lord Dufferin assist about 100 transient children in these schools to integrate into regular classrooms while staying with their mothers in emergency shelters.

With mostly private funding, we also operate a highly successful therapeutic summer day camp, called Camp Vimodausis, which serves about 48 children each summer whose behavioural problems would have prevented them from any other organized summer activity.

Earls court is known in the community as specializing in the treatment of aggressive, non-compliant children, typically from impoverished families. We have excellent working relationships with schools, child welfare societies and other agencies, and our clients are overwhelmingly satisfied with our services.

Research carried out by investigators at Earls court has identified the special treatment needs of children from Portuguese-speaking families and the special needs of children who witness family violence, as examples. Our studies have demonstrated reason to be cautiously optimistic about the outcome of our treatment programs.

Over the past decade Earls court has been active in the area of program evaluation and research. With minimal core funding and external grants we have demonstrated that some children do benefit from treatment and that in programs like our outreach project gains are sustained at six months and one year following treatment.

Earls court is at the cutting edge of program development and applied research, but we require significant increases in funding for programs and research in order to meet the demands for service and to ensure that programs are effective.

I want now to focus on the current crisis in the children's mental health sector, which was the focus of these discussions from the beginning. I have three major points.

The first is that aggressive children are different. There is a growing body of literature that suggests that aggressive children differ from their peers along several dimensions. They value aggression. They typically are suffering from another psychiatric disorder, such as depression and hyperactivity. They are less likely to attend to academic tasks than their peers. Many have learning disabilities and

are underachieving in school. Many are actively rejected by their peers.

These children are difficult to raise and their lifetime prospects are grim. They require more attention and closer supervision from their parents than normal children, and yet these children's high rates of whining and demanding behaviour, stubbornness and unresponsiveness to requests make them highly aversive to be around. Their parents are frequently under considerable stress, alienated from the mainstream of society and disfranchised.

At school these children are defiant of authority, destructive, disrespectful and disruptive. Their teachers and principals are frequently frustrated and overwhelmed by their behaviours. Often by the time a case is referred to Earls court the child's school feels it has tried everything and the working relationship between the school and the parent has reached rock bottom. These children are frequently suspended, threatened with suspension and placed on home instruction. They are at considerable risk of early school dropout, juvenile delinquency, adult criminality and adult psychopathology.

I regret to have to inform you that services in Metropolitan Toronto are shrinking. Due to consistent provincial underfunding of children's mental health services over the last 15 years, many services have been gradually cut back or discontinued altogether.

Let me describe some of the cumulative effects of this underfunding in Metro. Twenty years ago there were about 100 residential treatment beds for latency age children, children aged six to 12, in the Metropolitan Toronto area. Today in Metropolitan Toronto there are 24 such beds, fewer such beds than in Hamilton. Day treatment classrooms are decreasing and outpatient services have also been under siege.

As I listen to discussions around co-ordination, I am thinking that if you just wait long enough co-ordination will become easier, because there will be fewer and fewer services to co-ordinate.

We regret that by downsizing, for example, the catchment area in our family services department in order to offer immediate response to requests for help, we have simply become unavailable to certain children needing help who live beyond our service area and for whom other comparable services do not exist.

It is incumbent upon a caring government which is committed to children to ensure that resources are in place to allow centres like Earls court to help those children that other child-related sectors have given up on. We perceive a trend in government that seems to protect mandatory services at the expense of voluntary services. Consequently we are concerned that with no legislative guarantee of access to service, children with mental health needs who are not already receiving mandatory services will languish without the help they so desperately need. Children should be given the same legislative guarantee of reasonable access to mental health services as they currently have for physical health care and protection services.

Workers in children's mental health centres are underpaid. In transfer payment agencies like Earls court, salaries lag miserably behind salaries paid in directly operated On-

tario government facilities, such as Thistletown. This leads to resentment, low morale and high staff turnovers in our centres. The annual staff turnover in Earlscourt's residence, for example, is well over 50%. In the fall of 1988, over a three-month period of time, we experienced a 75% turnover. An immediate redress of the historical inequity in salaries in comparison with directly operated Ontario government facilities calls out for action.

Child care workers and social workers—female predominant professions—have traditionally been underpaid as a reflection of society's undervaluing of work with children. Recent union and pay equity settlements in directly operated Ontario government facilities have knocked the salaries in transfer payment agencies well out of the marketplace. This disparity is an injustice to our workers who certainly deserve and are entitled to salary equity within our sector. It is also an injustice to the children and families we are unable to serve because we cannot attract and keep experienced child care workers at our centres. There is an urgent need to achieve equity with wages paid to employees in the Ministry of Community and Social Services.

This human resource crisis is particularly acute, we feel, in the greater Toronto area where our workers experience a higher cost of living than anywhere else in the province. The combination of low salaries, the high cost of living in the GTA and our inability to compete with other sectors such as health and education have resulted in an intolerable situation.

As a result of numerous human resource and service crises in the greater Toronto area, 26 local children's mental health centres joined together to conduct a salary survey. We actually have a committee called the salary equity committee and I would just like to introduce members of that committee who are here and who helped with the report. We have John Spekkens from Dellcrest, Tony Deniz from the West End Crèche and Humphrey Mitchell from the Peel children's centre.

The attached charts I think clearly illustrate our desperate situation. We surveyed child care worker 1s, 2s, 3s and social worker 2s. These are the people who are working on the line with the children daily, often on a 24-hour basis.

If you look at the second chart, where we look at salaries in children's mental health settings. In this chart we are comparing mid-range salaries. The mid-range salary for a child care worker 1 in a transfer payment children's mental health centre in the GTA in comparison with the locally operated Ontario government facility is a whopping 41%. For child care worker 2, it is 30%. For child care workers 3s it is 21%, and for the social work staff it is 9%.

The child care worker 1s comprise—we are looking at 230 employees in the greater Toronto area in these agencies. For child care worker 2s, we are looking at 303; for child care worker 3s, 138; and for social worker 2s, 175.

The salary committee of the central region has met with representatives of the Ministry of Community and Social Services as recently as 2 o'clock this afternoon about this pressing issue. The ministry has acknowledged

the seriousness of the problem. What is required now is the political will to address it.

1640

The Vice-Chair: The chair wants to ask a question. am going to invoke my prerogative.

Mr Beer: Shocking.

Mr Owens: Resign.

The Vice-Chair: It has been a long day, I know.

Very briefly, I just want to comment on the report and also say that actually I am interested in the work that you do with culture-sensitive groups. You are located in downtown Toronto and I am obviously familiar with downtown Toronto, having grown up there, and also with the kinds of groups that are presently in downtown Toronto. It is a real catchment area. You must encounter a great number of recently arrived Canadians in that area, a large number of immigrants.

I am particularly interested in the work that you do with the Portuguese community because I know that as a result of their large number, in Toronto particularly, a great many problems are associated with children in the Portuguese community going through the educational system. I know that you have one worker on staff, as you pointed out in your brief. I think that is certainly inadequate and I am going to support your views on that and just simply say that there are not that many agencies dealing with the kinds of problems for those culture-sensitive groups. I do not know what we should do at this point other than to say that other agencies must look at that.

I am making a plea for that to occur within your own agency. I know that you will come back and say, "Well, we need more money," and there is certainly that to be concerned about. But there is just a horrendous problem with culture-sensitive groups. It is different because of that factor and the problems are multiplied and exacerbated because of the barriers that are faced, not only with language but really it comes down to culture, something that is a little more stressful.

That is my Chairman's prerogative.

Mr Malkowski: On a point of order, Mr Chairman: I am just wondering, is the Chairperson allowed to make comments or discussion during the committees?

The Vice-Chair: I believe that I am allowed to ask a question and I was trying to formulate a question out of all that.

Ms Haack: Actually I think I will be asking the same—

The Vice-Chair: Okay.

Mr Owens: Where is Steve Mahoney when you need him?

The Vice-Chair: We will proceed with Ms Haack.

Ms Haack: I flagged it for myself as you were going through it, about the issue relating to Portuguese-speaking families. I was interested that you used that one particular ethnic group as opposed to knowing, I do believe—Penny Moss is not here, but those people who were involved, say, with the Metro area school boards—that there are at least 80 languages taught in its heritage language programs. We

now that there are a vast array of ethnic groups situated in this four-million-population area that is called the greater Toronto area, so why the focus on this particular one as opposed to Vietnamese or whomever?

Mr Goldberg: There are certainly far more Portuguese children in this area than there are Vietnamese. There may be 80 or more ethnic groups, many in the city of Toronto and in the city of York, but there are more Portuguese in this area than any others, so I think the demographic data support our focusing on that. We gave a long time ago trying to be all things to all people, and in fact the designated Portuguese language position we have was developed out of a demonstrated demand for service and essentially cut back an English-speaking position in order to do that.

Numerous times we have asked government for funding to increase that capacity but have received no positive response. The whole issue of the delivery of services in a multicultural society and town is a complex one and requires further discussion. I am proud of the fact that we have a designated Portuguese position. When I have to say that our services are in English and Portuguese, I cannot apologize for that, because in fact attempts to broaden that have fallen on deaf provincial ears.

Ms Haeck: My reason for bringing it up was that you focused on that one ethnic group and you have substantiated why you have done that. Being an immigrant myself, I was sort of interested in seeing why you particularly focused on that group maybe other than somewhere else.

Mrs McLeod: Obviously one of the frustrations that all of the people who have appeared before us have is the inadequacy of resources to do all that they know needs to be done in their field. I guess one of the problems that creates is that there is often a competition for resources between people with similar kinds of concerns. I think it would be unfortunate to need to be pitting one against the other, although I know in reality that tends to happen.

I just wanted to get a little bit of clarification about a seeming tension between this presentation you have just made and the one that was made by the children's aid society a little earlier. You indicated that you felt as though mandatory services had received funding almost preferentially to voluntary service. Yet, the children's aid society earlier—you may have been here—suggested that the occupancy rate of children's mental health centres in the metropolitan area might be frequently as low as 73.9%, while the CAS occupancy rates, demand rates, would be higher than 100%. Again, I do not want to be seeming to exacerbate the tension by pitting one against another, but could you help us get a sense of why there seems to be that different perspective?

Mr Goldberg: I wish I could do it informally over coffee perhaps.

Mrs McLeod: Maybe we could substitute that.

Mr Goldberg: Perhaps another time. When I say mandatory, I mean in the context that if a child is seen in need of protection, it is expected that the child will receive it; such as education. All children are entitled to an educa-

tion. In the sense that the children's mental health sector has been withering on the vine, as has been stated before, we do see mandatory services protected.

I want to try to address the point. I am sorry that I missed the OACAS presentation. If there are children's mental health centres that are in the perception of any local children's aid society not adequately or fully being responsive to the needs of their children, I would encourage them to have dialogue with their local children's mental health centres and to have dialogues that involve perhaps the area office where they are located. I cannot help but think that with a little dialoguing and a spirit of co-operation, changes could occur.

Mrs McLeod: The vacancy rate then is not a reality for you?

Mr Goldberg: We are at 100% occupancy, one child receiving specialized one-to-one funding in order to provide him with 24-hour care.

1650

Mr White: I am very impressed with the evaluative research component that you mentioned. Earlier this afternoon we were informed that was not something which occurred regularly in children's mental centres and that as a result those services were often trying old methods, which may or may not be effective or may or may not be more good and bad, as I recall the phrase was.

In using that evaluative research in relation to the residential component, and you mentioned specifically the aggressive children which your centre services—I imagine those are most likely to be the kind of children to who would be using the residential services—what does that research tell you about the need for that kind of a service as a core, perhaps, of children's mental health centres?

Mr Goldberg: I guess it is our really firm conviction that residential treatment ought to be on a continuum of less intrusive, less intensive services. There is a valid role for it. The current trend would be to decrease, actually, funding for non-residential services in order to maintain the few residential beds that we do have in Metro Toronto. As indicated, there are fewer in Metro Toronto than there are in Hamilton.

I would like to clarify, and it relates to Ms McLeod's point as well, that we have eight beds; four of those are designated for children's aid societies and in fact the other beds are also available to them. The use of those beds and the use of beds in the other two agencies in Metro providing residential treatment to latency-age kids, Dellcrest Youth Services and Aisling Centre for Children and Families, meet monthly with the ministry rep and the children's aid societies to co-ordinate the most effective use of those very limited beds that are there. So there is very close collaboration that way.

I would say that residential treatment is very important, but the non-residential services in terms of secondary prevention are very, very important as well.

Mr Owens: First of all, I would like to congratulate you on your report and to take on this issue of pay equity and wage disparity that we have in the helping professions. As a person who comes from a hospital setting, I can tell

you that the expectation is that people do not work in these jobs solely for money but for, I guess, a personal sense of satisfaction, and that sometimes is used as a hammer over their heads when it comes to, I guess in your situation, contract negotiations with the unions.

It is my sense that this government will not shy away from trying to close up some of those discrepancies, as we have heard from several presenters and again from yourself, with an acuity that is astounding, that we will try to address those kinds of problems so that we do not have issues of burnout and 75% turnover rates. I find that is appalling and it certainly does not help the children in any way, shape or form and it does not give the workers any sense of self-worth in their own professions.

The Vice-Chair: I think we have come to the end of our session, unless there are any further questions. If not, I would like to thank you for your presentation, for taking the time to come before us.

To members of the committee, I need direction from you with respect to our meeting tomorrow. We can meet in camera if that is the wish of the committee, or we shall continue to meet open to the public? What direction can you give me on that? Is there a desire to meet in camera, or shall we just continue the way we have been? We can do it either way.

Mr Martin: Continue the way we have.

The Vice-Chair: Consensus on that? Yes, okay, fine. We will meet at 2 o'clock tomorrow afternoon, Wednesday 16 January.

Let me just thank members of the committee for their co-operation in this most pressing and difficult endeavour of keeping on time. Thank you very much.

Mr White: I was wondering about the arrangement of the tables here.

The Vice-Chair: Rearrangement.

Mr White: Rearrangement. I am wondering if this could be changed back the way it was. I understand there is only one member of the Legislature to whom we should be extending our backs.

The Vice-Chair: The clerk would like to address that.

Clerk of the Committee: The reason for the change in the setup is twofold. Number one, and most important if you have another member of your caucus who wants to come in or if any other members of any other caucus come in, in the other setup there is absolutely no way of accommodating them. That is the main reason. The other reason is this room is very small, as you saw over the last couple of days, and we were not able to get the audience seating in here that we needed yesterday. Those are the two reasons.

The Vice-Chair: The truth is I almost broke my knee.

Mr White: They can be rearranged.

Clerk of the Committee: What about other members of your caucus who may come in and cannot be accommodated?

Mr White: In the event that occurs, I am sure we would be willing to give up our seats for them or make arrangements.

The Vice-Chair: Do we need a ruling on this?

Clerk of the Committee: No.

The Vice-Chair: I do not think so. Can you talk to the clerk further about it? Do you want me to debate this? I would like to adjourn the committee.

Mr White: Why do we not rearrange the tables?

The Vice-Chair: Okay, we will talk about it later.

The committee adjourned at 1657.

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STANDING COMMITTEE ON SOCIAL DEVELOPMENT

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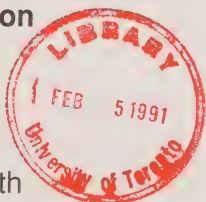
**Official Report
of Debates
(Hansard)**

Wednesday 16 January 1991

**Standing committee on
social development**

Organization

Children's mental health
services



**Assemblée législative
de l'Ontario**

Première session, 35^e législature

**Journal
des débats
(Hansard)**

Le mercredi 16 janvier 1991

**Comité permanent des
affaires sociales**

Organisation

Services d'hygiène mentale
pour enfants

Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
Greffier : Lynn Mellor

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 16 January 1991

The committee met at 1400 in committee room 2.

ORGANIZATION

The Vice-Chair: Order. The committee is in session. Mr Owens has a point of order.

Mr Owens: Mr Chair, on a point of order, just a quick item of business: I have spoken with the other two whips, Charles Beer and Elizabeth Witmer. We have received a request from the Federation of Ontario Facility Liaison Groups, from Margaret Paproski, who is the president of his organization. She has requested that we add her to the list of deputants under the multi-year plan, and I have agreement from the other two parties that we do that. Do we pass the information to the clerk now to contact her, or can we do that through the minister's office?

The Vice-Chair: That would be for a deputant to appear before the committee next week, on one of our designated days.

Mr Owens: That is right.

The Vice-Chair: Would you please pass that information, if you have it available right now, to the clerk.

Clerk of the Committee: Does this mean that you are amending the previous report of the subcommittee concerning standing order 123?

Mr Owens: That is right.

Clerk of the Committee: And this has unanimous consent?

Mr Owens: That is right.

The Vice-Chair: We have unanimous consent. All three members of the subcommittee have agreed, so we can add the group.

Mr Owens: I need to get this photocopied. I will pass it to the clerk as soon as it is done.

The Vice-Chair: Terrific. Are there any other items of business before we start into our report? I do not see any, or perhaps we could start.

CHILDREN'S MENTAL HEALTH SERVICES

Resuming consideration of the designated matter of children's mental health services pursuant to standing order 123.

The Vice-Chair: We will now begin our deliberations on the draft report. I remind members that we have approximately two hours. I would like to confine our discussion to a little less than two hours. That will permit us to have a half-hour to approve final recommendations, the final report, on Monday following, at which time we will be meeting in the afternoon to consider that.

The committee will be meeting at three o'clock on Monday 21 January and the subcommittee will be meeting

at 11:30 am to clear up any difficulties with that final report. Is that acceptable to everyone?

I would like to proceed now with our draft report. I will turn it over to our research officer.

Ms Drummond: If everybody could turn to page 11 of this document with the research services letterhead on it, this is solely for the use of the committee. I thought it might be convenient for the committee to have in one place the specific recommendations that were made by various witnesses. So I have tried to collect those out of all the documents that we received up until yesterday afternoon. I see there is one more. This is not even necessarily a format that the committee may want to stay with. It is just for reference.

The Vice-Chair: Has the subcommittee met to discuss the format of the report? Or you have not done that at all?

Mr Owens: No, not at all.

The Vice-Chair: We should proceed on the basis of dealing with the content of the report and how it is set up, and then deal with recommendations. Is that how you would like to proceed? I am open to suggestions here.

Ms Drummond: In the last Parliament, in the last Legislature, this committee did a report on food banks under this standing order and the contentious parts were essentially the recommendations. The covering memo explained what the body of the report is. As you will see, it is not entirely complete, because I was not able to put in everything that we got from the witnesses yesterday.

If individuals have concerns about that, I would appreciate hearing about them over the next few days. It would probably be more productive for any concerns in the body of the report to be sent to the subcommittee for Monday morning. This part of the committee is really to give me some guidance on what the recommendations might be.

Mr Beer: I know that our time is very limited. We have just received this document, and I will throw this out for questions. Do we want to stop so that we can all have a chance to look at those recommendations and meet, I would suggest, in 15 or 30 minutes, but just something whereby we can look? It is very helpful to have this, but then that would not be a formal part of our meeting. It would just give us a chance to look at those, to look at the notes we have made about things we thought we wanted to include, and then to begin again in 15 to 30 minutes, having had a chance just to look at these and be able to be a little more specific. I make that as a suggestion.

The Vice-Chair: Mr Hope, I do not want to take up too much of our time here.

Mr Hope: No, exactly. I believe we ought to have an opportunity to review the documents that have been

presented by research. Just listening to Charles about some his comments that he is quoting, they do have recommendations and I guess we also have recommendations and we do not know necessarily if they are embodied in here. I think it is appropriate that we take a little bit of time to discuss and to look at what is being presented to us today. That is just my personal concern. It is not concerned with the topic.

The Vice-Chair: I want to turn to the Conservative Party members and give them an opportunity to have input into this.

Mrs Witmer: We want to read the information first.

The Vice-Chair: Okay. I think then it is appropriate at this point to adjourn the meeting at least, I would say, until 2:30, for 20 minutes, to give us an opportunity to go over the report. We will reconvene at 2:30 and then begin our deliberations on dealing with the actual recommendations. Is that agreed? Mr Owens?

Mr Owens: Sure. Can I just ask a process question?

The Vice-Chair: A process question, yes. Let me adjourn the meeting and then we can deal with that. We are adjourned.

The committee recessed at 1408.

1452

The Vice-Chair: I call the meeting to order once again.

I will make my remarks very brief at the beginning here. We are just going to be looking at recommendations and the body of the report, as pointed out earlier. If there are any difficulties with that, it should be and could be brought up with the subcommittee members for further discussion. But we are going to deal with recommendations, and I hope everyone has had an opportunity to look at the recommendations that have been put forward by our research officer.

Mr Jackson: If the subcommittee is not going to meet until Monday morning, could we take a limited 5 or 10 minutes just to discuss the first pages dealing with the narrative aspects of the report and then move into recommendations quickly? I have only three or four points we would like to raise. I think it may be helpful for Alison to get that now versus Monday.

The Vice-Chair: Do we have agreement to do that? Mr Jackson's suggestion is that we briefly look at the body of the report and then we give direction to Alison with respect to recommendations after that. Is that correct? You want five minutes to do the body of the report.

Mr Jackson: Five or 10.

Mr Owens: If Mr Jackson would like to make his recommendations, we in breaking did not study the narrative portion of the report. I would be glad to entertain that as a member of the subcommittee.

The Vice-Chair: Why do we not do that? We will deal with that in subcommittee, if there is time at the end of this session. You obviously have not had time to look at the narrative or the body of the report. If there is still time, then we can deal with it in five minutes.

Mr Beer: If it is just a matter of putting on the record some of the thoughts that they want to make sure are being discussed, I would think we could take 5 or 10 minutes and just do that.

Mr Owens: I do not have a problem, as I said, with its being put on the record.

Mr Beer: We have not looked at that but I would like to know what your concerns are. We may share them. Not necessarily concerns but additions or whatever.

The Vice-Chair: Am I to understand there is consensus to allow for Mr Jackson to put his concerns on the record?

Mr Jackson: No. I would like to take 5 or 10 minutes for anybody to contribute to the narrative portion, if there are some things that jump out at them, so that that is very helpful to Alison. Waiting until Monday so that she meets with the subcommittee in the morning and then presents to the whole committee in the afternoon is running her real tight.

The Vice-Chair: Do I have consensus to do that?

Ms Haack: Just to be expeditious and in no way to interfere in any way with this process, as Mr Owens has already mentioned to you, as a caucus we did not take the time to go through the narrative. We solely looked at the recommendations.

What I think we should be doing is that each caucus go back. At this point we should be looking strictly at the recommendations and overnight looking at the body of the narrative to suggest to our representatives, the whips, what we feel should be added and that the subcommittee deal with whatever additions there are.

I can foresee the process of that 5 to 10 minutes ending up a whole lot longer and we are moving this a whole lot further around in time than really was allotted. I think we can probably handle this very expeditiously through the representative whips and the subcommittee can add or delete whatever it feels is appropriate and it can be brought back to us on Monday.

The Vice-Chair: I, therefore, understand that there is no consensus to put forward Mr Jackson's suggestion.

Mr Jackson: I think the last speaker summed it up. We have spent so much time debating whether or not we should talk about it that we could have got my three or four quick points on the record so that the NDP could understand them when it was doing its own analysis. Unfortunately, that is not the direction we are going.

The Vice-Chair: That is not the direction we are going, so we are going to move forward at this point.

Mr Jackson: That is fine. We will share them with you on Monday.

The Vice-Chair: We are going to move forward and deal with recommendations as we planned to do and we will deal with the rest as we go along.

I turn my attention to our research officer to direct us through her list of recommendations. We obviously have a set of recommendations from each of the parties which we will try to blend with the rest of the recommendations that have been put forward by our research officer and deal

with those on each basis as they come forward from each party. All right? Can we proceed?

Mr Owens: Mr Chairman, do we have the recommendations from the Conservative Party as well? We are ready to go and I have copies.

The Vice-Chair: You have copies for each of the members. Why do we not ask the Conservatives? Do they want to share their recommendations?

Mr Jackson: I think we had indicated already, Mr Chairman, that we had met earlier today and that we hoped to have them by day's end in a written form. That is on record.

The Vice-Chair: All right. I am sorry if all members did not hear that. I apologize. I should have taken note of that.

Mr Owens: In terms of my understanding of today's meeting, I guess I would like to understand what the end of the day means. Are we going to have them within the context of the two hours that we have today?

The Vice-Chair: Is four o'clock okay?

Mr Jackson: No.

The Vice-Chair: Five o'clock?

Mr Jackson: I will talk to my researcher who is working on it. We hope to have them done by day's end and we are going to make every effort to do that. We can certainly get it in their hands first thing tomorrow morning.

The Vice-Chair: Is this going to be a real point of contention?

Mr Jackson: It is not even a legitimate point, Mr Chairman. I am just telling you when I can get our stuff together. It is a point of information, not debate.

The Vice-Chair: Okay. Shall we proceed knowing that?

Ms Haeck: No.

Mr White: How can we discuss what is not here?

Ms Haeck: We have managed to get ours together.

The Vice-Chair: Just a moment. Let me try to bring some sense to this. We will be proceeding with the recommendations that have been put forward by our research officer. We have time allocated to us to do so. If you do not wish to put forward your recommendations as a result of the information you now have before you with respect to the Conservative set of recommendations, that is your option. But we will proceed with hearing the research officer and her list of recommendations. That is how I intend to proceed.

Mr Owens: Not to exclude the Conservatives from the process, but our concern is that we are limited to the 12 hours. How are we going to be able to fully discuss the recommendations from the Conservative Party if we do not have them at this point? Our intention is not to exclude; we want to include so that we can fully participate.

The Vice-Chair: I am trying to deal with all of these things in a fair and equitable fashion, but if the Conservatives do not have their list of recommendations in written form, then I think that is a more a matter of inconvenience

rather than a case for me to halt the proceeding of the committee until they get their recommendations. Short of that, I do not know what else we could do at this point other than to proceed.

Mr Jackson: We have discussed all this. We broke once already from these committee hearings with the understanding of how we were going to proceed. Now we are taking up valuable time discussing the process we discussed 35 minutes ago. I am sorry to bring that to everyone's attention, but I understand that we were going to proceed with the recommendations. I made a simple suggestion that we look at the narrative very briefly. It was not a consensus. I thought we were just naturally going to start looking at Alison's recommendations as we heard them and get some discussion and feedback and, to the extent that we could contribute from our own caucuses, we would do that as we were able. That is what I understood your directions were.

The Vice-Chair: If there was a misunderstanding, that might be the case, but I intend to proceed.

Mr Jackson: As I just described it?

The Vice-Chair: I intend to proceed with our hearings. This is the day we have to do that and this is the time we have scheduled to do that. I am looking for direction and I am looking for a consensus. Seeing no consensus—

Mr Jackson: I am looking for a ruling. I have heard "consensus" from you on three or four occasions in the last five minutes.

The Vice-Chair: A ruling will be made. I have already indicated to you that I intend to proceed with our deliberations.

Mr Jackson: That is exactly what I heard you say. I am waiting for us to proceed.

The Vice-Chair: That is a ruling. I do not have to reiterate it.

Mr Jackson: Great. I am not challenging it. I am encouraging you to get on with it.

The Vice-Chair: I am going to entertain one more comment from each of the parties and then we will proceed.

Mr White: I just want to make a point of clarification; I am sure you will accept this in a friendly manner, Mr Chair. The point was made both by yourself and Mr Jackson that the recommendations listed were from Ms Drummond. In fact, they are not her recommendations or the recommendations of the committee but simply a list of the recommendations from the witnesses, and in no way is it incumbent upon us to accept them, especially as many of them are contradictory.

The Vice-Chair: Is there a comment from the other two parties? One final comment and then we will proceed.

Mr Beer: As you noted, we are here. I think we should go forward and look at the recommendations. With the recommendations we receive later this afternoon, the subcommittee—I would make the commitment with Mrs Witmer and Steve Owens that we would look at those tomorrow morning or later this afternoon. If those

presented a problem in terms of our discussion and those kinds of things, then the subcommittee could determine that we are going to have to do something between now and when we come back together on Monday, just to be fair. But these are here, we have some time, and I think what we have put forward is just to be helpful, and I think much of it does fit in with what has been recommended. There are a couple of issues we want to discuss with everyone.

Mrs Witmer: I would concur with Mr Beer. I am not sure why we are delaying. Many of the recommendations we would be putting forward would be similar to what has been put forward by the witnesses, and I would suggest that tomorrow the subcommittee could meet to discuss anything else.

The Vice-Chair: Okay. We will now proceed with the list of recommendations from witnesses which is contained in our report.

Mr Hope: On a point of order, Mr Chairman—

The Vice-Chair: Is this on a different matter?

Mr Hope: It is pertaining to this whole issue we are talking about.

The Vice-Chair: I have made a ruling, unless you wish to challenge the Chair.

Mr Hope: I just wish to point out something. You are saying it is all new. I have been listening to what has been taking place in the conversation. Yes, we are running out of time. We all sat here listening to the presentations. The researcher has now put it on paper. We listened and now we have to develop recommendations. We are arguing about whether we are going to review these or review what we have put together. I think we had better review what the parties have developed, because this is just reiterating the briefs. I think we have to move in a progressive way, not a regressive way, in making sure things happen for the children. We are sitting here arguing, and I am saying we have a prepared document that we wish to share and debate upon.

The Vice-Chair: I have been very patient in addressing everyone's concerns and I have made a ruling. I intend to proceed at this time unless there is a challenge to the Chair.

Alison Drummond, our research officer, will you proceed with the list of recommendations in the report?

Ms Drummond: If everybody could turn to page 11, I have organized the various specific recommendations made by witnesses in terms of goals and principles, problems of access to services; on the following page, recommendations involving co-ordination of delivery of services; and on page 14, various recommendations that were made for changes in the funding process; and finally, research needs. That is just one way the recommendations could be organized. I am open to any guidance from the committee about whether that is an appropriate way to organize and how the committee wants to treat the recommendations by the witnesses.

The Vice-Chair: Is there any discussion or debate on this item? Any suggestions on how we should proceed

with respect to these recommendations from witnesses? They are listed. In the past, if I could bring my limited experience to bear on this, I think we have always in a report listed recommendations from witnesses as they were presented. I do not see any difficulty with doing that. Unless the committee disagrees, we should do that.

Mr Owens: A simple listing of the recommendations as opposed to adopting them as the committee's recommendations?

The Vice-Chair: It virtually gives us a summary of what we have heard in capsule form. That is all we are doing here.

Mr Martin: I am wondering if it is valuable to spend our time going through something we spent the last two days listening to, whether we should not move into—this is where I have a concern—the recommendations which the two parties which have presented some positions have made, so we can see if there is some consensus on that, on a report we would move forward. I think we are going to have a real difficult time here this afternoon with all of this.

The Vice-Chair: We are having a difficult time.

Mr Owens: You are earning your \$90 a day. Come on.

Mr Martin: I would suggest humbly that we take what we have, wait for the PC recommendations to come later this evening and that we get a chance as a caucus to take all of that material and go through it and then come back on Monday with some further refined recommendations that we could probably more readily agree on, because we have seen what everybody is putting forth.

The Vice-Chair: I think I have made it very clear, as the Acting Chair of this committee, that there is a limitation on us with respect to time. We cannot order our business beyond the time we have been given. It is impossible to do what you are suggesting. Mr White, on the same point?

Mr White: Slightly different.

The Vice-Chair: I want to deal with the matter before us, with respect to recommendations that have been put forward by the research officer.

Mr White: A couple of points. I would like to move acceptance of the report, an excellent summary of the presentations and of the narrative end of the recommendations that were before us, an excellent source point for further review. Of course, the recommendations which the Liberal caucus and ourselves generated were from these very points. However, after having used that, I think we as a committee need to discuss where it is we are going. We do not appear to be ready to do so at the moment. I would suggest that we simply accept this report and adjourn until such time as the third party representatives deem that they will be ready.

Mr Jackson: First, I want to clear up one misapprehension that all the new members may have. We have only had two committees that have done these 12-hour allotments. I had the privilege of working on one of them on food banks. The NDP did not table its recommenda-

tions. We proceeded. We had no difficulty. At the eleventh hour, they pulled out a minority report. That was fine, too; it was their right to do so. In no way was it seen by the Liberals or the Conservatives, at that time, to be disruptive. It was just the manner in which they were willing to proceed. I am going to further state for you that there is no specific strategy that there was perhaps in effect at that time. We are just simply stretched and we do not have it in written form.

The Vice-Chair: I have a suggestion.

Mr Jackson: I just want to clarify some assumptions.

The Vice-Chair: This is the Chair's prerogative. I would like to stop the clock. Perhaps we can proceed with our debate without using up any more of our time for our recommendations. Let me adjourn.

Mr Owens: On a point of order, Mr Chairman: Can I make a motion or a suggestion that we hold these discussions on the process in camera?

The Vice-Chair: I need a consensus from the committee to do that.

Mr Jackson: I do not support in camera meetings. Under most every circumstance, I do not support them. Stop the clock but do not ask people to leave the room.

The Vice-Chair: I will stop the clock, adjourn this part of our session and try to deal with this in 15 minutes. That is what I am going to give us to discuss his matter in terms of how we proceed. Is that agreeable?

The committee recessed at 15:11.

1519

The Vice-Chair: Order.

Mrs McLeod: I think it is important and I wanted to make the statement on the record that we not be under any illusions about the task we have undertaken, with 12 hours of committee hearings on one of the most complex and comprehensive subjects that we could possibly have undertaken. I hope we do not believe that in those hours we have heard all there is to hear, understood all of the perspectives, have them absolutely clear in our minds, and then can move to make recommendations which are comprehensive and all-inclusive. I really believe all we have done is opened the field of children's mental health so that we understand the complexity and the questions, and are ready to make some commitment and call for some commitment to getting on to addressing those questions.

The Vice-Chair: I am going to suggest, as the Chair, that someone put forward a motion to adopt the recommendations that have been put forward by our research officer and deal with those.

Mr White: I had put forward that motion.

The Vice-Chair: You moved that? Is it seconded?

Mr White: The motion was that we accept the report of Ms Drummond, the research officer as a point of information and discussion.

Clerk of the Committee: And be added to the full report as the recommendations of the witnesses.

Mr White: Yes, as recommendations of the witnesses.

Clerk of the Committee: It would be an appendix to the report.

The Vice-Chair: Do we have agreement on that?

Mrs Witmer: I second it.

Motion agreed to.

Mr Martin: There is a report on the back of this from the Ministry of Education. Is that part of the packet?

The Vice-Chair: That is not part of the report. That is just for your information.

We shall now proceed to deal with recommendations by this committee to the Legislative Assembly. Are there NDP recommendations or Liberal recommendations?

Mr Owens: Again, in terms of process, before we get into wrangling, whichever group we decide to deal with, shall we deal with the recommendations in their entirety or one at a time? Again, it is a process question.

The Vice-Chair: I think it is appropriate to deal with them one at a time and deal with them in as detailed a way as possible with the limited time, keeping in mind the limited time we have. Can we do that? I think we will start with Liberal recommendations and then move to NDP recommendations. Is that acceptable?

Mr Beer: What we were trying to do here was set out an approach. I do not know whether the best thing is to read these through and then have discussion, but I am conscious of time. First of all, in the first one, looking at the question of a vision, it just seemed it was important. The first one speaks to a question of vision and how we approach children, and we are recommending that the government use the Children First report as a basis to initiate a progressive agenda for children.

Again, that is partly in terms of what Lyn was talking about, that in the nine hours of hearings we cannot pretend to understand everything and to set out all of the answers, but we thought we needed to start somewhere and that vision is something we would be asking the government to come forward with.

The Vice-Chair: Could I make a suggestion that we read each of the recommendations. Each of these has been passed out.

Mr Beer: Yes.

The Vice-Chair: Every member of the committee has a copy of these recommendations, correct?

Mr Beer: I believe so.

The Vice-Chair: I would like to proceed in as expeditious a fashion as possible. I am trying to sort that out.

Mr Beer: How much time do we have?

Mr Jackson: I might suggest that reading them verbatim into the record invites grammatical changes and the whole ball of wax.

The Vice-Chair: I am informed by the clerk that we must do that in order to approve recommendations.

Mr Jackson: I understand that.

The Vice-Chair: What I was trying to do originally was get consensus on the recommendations that will be put in the report.

Mr Jackson: I did not know you and I were going to debate the issue.

The Vice-Chair: Please allow me to finish.

Mr Jackson: I thought I had the floor. If we were going to entertain a debate, then that is fine, but I understood that when you recognized me I could share with you my suggestions, for which you had asked. I was in the process of sharing that with you when you cut me off.

The Vice-Chair: Actually, I did not ask for your suggestions, but you can proceed now.

Mr Jackson: No, you did not ask for mine particularly; you asked the group in general. I was simply offering a suggestion. It is your right to interrupt me, but I am unaccustomed to that in this building.

The Vice-Chair: You are not accustomed to it?

Mr Jackson: No, I am not when I am in order.

The Vice-Chair: We will not have a further debate on that.

Mr Jackson: You did not rule me out of order. You interrupted me. Robert's Rules of Order—read them.

The Vice-Chair: Unless you wish to debate and challenge the Chair—

Mr Jackson: I did not.

The Vice-Chair: —I am going to cut you off at this point. I think what we should do is proceed with respect to the recommendations that have been put forward by the Liberal Party. We will deal with them each one at a time, and if there is no consensus then we will deal with the matters that are not in agreement. We will start with the first recommendation.

Mr Beer: I think, as we have said, we are dealing with a new process here and one of the difficulties we are all finding is that we are looking for the first time at a number of different recommendations. We have put ours forward obviously in the context of having a discussion. The wording of them is not necessarily set in stone. Perhaps something we are going to have to come to grips with is, how do we get that kind of give and take discussion that encompasses the New Democratic Party recommendations and our own? I guess I was seeing that at the end of that the indication is then to our researcher who would go away and try to put those together.

I am concerned that if I am to read each of these and we are somehow to have to vote or whatever, it seems to me we probably do not have time to get through the first couple of these. How do we discuss and then have those crafted so we end up with something that is not New Democratic or Conservative or Liberal, but rather reflects the consensus? I just see a problem with process

here that is interfering with our attempt to deal with the substance.

Mr Jackson: Mr Chairman, a point of order—

The Vice-Chair: Just a moment. A point of order: I will entertain that and then I want to make a final comment.

Mr Jackson: Mr Beer has made the point that I was attempting to make, so he will have our full support. That was entirely the point I was trying to make before I was cut off.

The Vice-Chair: I apologize for any inconvenience to you personally.

Mr Jackson: It was only meant to be helpful. I appreciate that.

The Vice-Chair: Okay. I appreciate that.

Mr Martin: I appreciate what Mr Beer has just said as well, and take his earlier comments to me as very constructive.

Mr Jackson: It's the way to go.

Mr Martin: Okay.

The Vice-Chair: Do we have agreement on that? Can we proceed in that fashion?

Mr Martin: I just wanted to comment on his comment, because we were into somewhat of a discussion on this here and I think it is important. Time is of the essence. As Mrs McLeod said earlier, this is an important issue and we need to come up with some good recommendations. If we are going to sit and debate each one of these for hours, we are going to be here for ever. That is why, I guess, earlier I had said that we are going to have a really difficult time with just these two than the Conservative one later.

If somehow we could put in place a process that spoke to perhaps groups of us, and the generic groups are the ones that are here right now, the Liberals, Conservatives—taking these away and working them over and seeing if we cannot put our report together with your report, so that we can all agree on it, and give it to the research person to take away and incorporate into some food for thought for us for the next meeting. Perhaps we might arrive at something. Otherwise we are going to go on for ever.

The Vice-Chair: I am trying to get advice from the clerk in terms of how to proceed.

Mr Owens: I was going to recommend that we stop the clock at this point.

The Vice-Chair: I think we are going to have to do that. Let me recess the meeting.

The committee recessed at 1530.

1608

The Vice-Chair: I call the committee to order. We will hopefully restore some sanity to this process now. We have agreement by the subcommittee. Its report is to proceed in this fashion: the subcommittee will be meeting and conferring with each other tomorrow at some point with respect to the three lists of recommendations we have, which the research officer has been directed to

amalgamate and synthesize, so that we will then have a list of recommendations. Some consensus will be reached by the time the subcommittee meets on Monday morning, which has been scheduled for 11:30 am. So you will be discussing this tomorrow after the researcher has been given time to amalgamate all of the recommendations by each of the parties, put them together in a digestible format and separate out those issues which are contentious.

It does not mean we will not have time to debate. We still have an hour and 45 minutes remaining. We will be

meeting to consider those final recommendations which can also be amended, so nothing is absolutely final until we meet as a full committee on Monday. That will take place at 1 pm on Monday, at which time we will then proceed to deal with final recommendations which will then be voted on and adopted. Is that acceptable to everyone? Good. We will adjourn and this committee will meet again at 1 pm on Monday 21 January.

The committee adjourned at 1610.

ERRATUM

No.	Page	Column	Line	Should read:
S-8 1990	S-112	2	33	Agreed to.
				The Chair: We will begin now with

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Clerk pro tem: Carrozza, Franco

Staff: Drummond, Alison, Research Officer, Legislative Research Service



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Standing committee on social development

Children's mental health
services

Organization

Service mandate for
developmentally handicapped



Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 21 janvier 1991

Comité permanent des affaires sociales

Services d'hygiène mentale
pour enfants

Organisation

Mandat de services relatifs
aux déficiences mentales

Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 21 January 1991

The committee met at 1313 in committee room 2.

CHILDREN'S MENTAL HEALTH SERVICES

Resuming consideration of the designated matter of children's mental health services pursuant to standing order 123.

The Vice-Chair: Members of the committee, we are now going to be sitting for an hour and a half, and hopefully we can get our business done because I remind members we have witnesses appearing before us on our next item on the agenda at 3 pm. I hope we can get through this process rather quickly.

Everyone has been given, and I believe the clerk has circulated, our revised draft in two pieces, actually, recommendations and body of the report. I think it is prudent to begin by looking at the recommendations, go through those and then come back to the body of the report. Perhaps our research officer could take us through that, detail the changes that have been made and go through that process now.

Ms Drummond: Perhaps everybody could look at page 9 of the draft report which was faxed to everybody on Friday. I am missing page 9 myself. The subcommittee met this morning and the result of that meeting is what was just given to you, which is headed "Revised Recommendations." These were the recommendations where there was a certain amount of consensus reached this morning. Should I take everybody through the changes that were made this morning?

The Vice-Chair: I think so. Let's zero in on those things and then if there are any further discussions, we can deal with that after.

Ms Drummond: As you will see, there were some changes to the preamble. I was asked to redraft it to make it more positive and there were some further changes this morning. As you will see, there was a clause added to the first sentence, "...there is general agreement that many children are not receiving care in a timely and appropriate manner." The original second sentence of the preamble was dropped. The subcommittee agreed to drop it.

On the "Access to and Co-ordination of Services," the first change originated in my misunderstanding, and the subcommittee had agreed that the implementation committee should be set up and make a report by the end of September. I made the other changes on the representatives for stylistic reasons. The recommendations on the implementation committee were strengthened slightly, saying that "should address" rather than "could."

The subcommittee agreed that the first two bullet points under "Other issues" could be folded together into one which now reads "gather systematic information on the children on the waiting list, using the report by Craig

Shields commissioned by the Ministry of Community and Social Services."

The change at the bottom of that page was simply a stylistic one. "How to use" seemed a little awkward and so it is now simply "making better use of."

On page 10, the subcommittee wished to simply strengthen that first sentence, so it is now simply "We recommend." The second bullet point has been changed slightly to read "residential centres in the province should receive adequate funding to ensure the safety of children and staff."

Under the fourth bullet point, "prevention programs such as the Better Beginnings, Better Futures initiatives," simply so that is not constrained, that other prevention programs could be funded.

Finally, the point of the last statement was to encourage co-operation by different agencies. Co-ordination is also an issue of course, but "co-operation" seemed to reach that more closely.

Under "Research, Evaluation and Training," the preamble was changed slightly, as you will notice. It is the Premier's Council on Health Strategy. That is my error. Mr Beer has suggested that "request" might be a more appropriate verb to use rather than "assign" since it is an independent body.

The third bullet point under "Research, Evaluation and Training" was changed to address the issue that there are human service problems in the field throughout the province and that there are unique needs in the north. There should be a semicolon after that; I missed that. The subcommittee wished to emphasize that the Premier's Council should also be consulting a range of people in the field.

Under "Native Issues," the preamble again was changed slightly. On page 11, simply the preamble was strengthened.

Finally, on the last set of issues, the subcommittee agreed that both language and culture issues should be addressed since one of the witnesses from the Earlscourt Child and Family Centre raised the issue of services to multicultural groups.

I guess now the question is which set of recommendations the committee should be working from. I would suggest it might be a little more convenient to work from this one called "Revised Recommendations."

1320

The Vice-Chair: Obviously this reflects a consensus of opinion from the subcommittee members in bringing together all of the various recommendations. I think at this point, if there are any discussions or debate on the recommendations as they have been put forward, it would be appropriate to entertain discussion on these, not that there has to be discussion, but certainly there is time for any discussion that committee members deem appropriate. I

open the floor to discussion of the way in which these recommendations have been put forward. Would committee members like me to move forward, if all is agreeable, in terms of the recommendations?

Mr White: There is a significant change, I think, in the preamble. Many of the recommendation points that Ms Drummond mentions are tidying up efforts, but in the preamble the change actually, I believe, is significant and omits basic issues about family disruption and child poverty which came clear, certainly in Dr Offord's report and various other witnesses, as being significant contributors. In the revised recommendations, those references are not there. I wonder if we could have some comment as to why those changes have been made or that particular change was made.

The Vice-Chair: Would one of the members of the subcommittee like to address that and then we can discuss it along that basis?

Mr Beer: Let me try to recall our discussion on this and there may be a way of working that out so the concern you have is expressed. There was a concern that this seemed to indicate that income was the only reason or the basic reason why children had mental health problems. I guess it was that the physical needs of children were expressed there in terms of shelter, food and clothing, but that then there were also emotional needs.

It was not that one was trying to say that is not part of the problem, but trying to find some way of indicating that there are the physical needs and the emotional needs. That was why we thought then we will look at it that the emphasis is on healthy children. Perhaps that encompasses it. Now, I recognize that when you make changes that could take away, and perhaps there is a way of expressing the point you raise as long as, I think, there is a need as well to express the concern around emotional needs, because all kids of whatever income level may also have mental health problems that are not fundamentally in terms of income.

That was kind of what we were wrestling with.

Mr Owens: I agree with both Charles and with Drummond that certainly poverty is an issue that contributes to mental health problems, but we did not see ourselves wanting to make it seem like it was simply an income-driven issue. We agree that there is a problem. We agree that the problem needs to be attacked at its root and this was maybe not the best way, as we are only human, and maybe you can propose a better way of framing that kind of philosophy.

Mrs Witmer: I can understand what Mr Drummond is saying. I guess what we wanted to do was to be very positive in our approach. What we want to make sure is that with all children, not only are their physical needs going to be met but also their emotional needs. Certainly, we saw many different reasons for children suffering behavioural and mental illness problems. Some of it was because of single-parent homes, family violence, etc. Certainly that occurs in more than just homes where there is poverty. We wanted to be very positive and talk about helping families raise healthy children. That would mean we would do whatever we can, and obviously one of the

things we would want to eliminate is poverty and whatever else we can.

We are focusing here very much on what we can do and I do not think we want to label and somehow point out that only children from poor homes are suffering from these problems. It is children from across all levels of society.

Mr White: If I could respond, I think again that a number of these points were mentioned. I would agree wholeheartedly with Mr Beer that implicit in a number of the recommendations are those very points, those very issues. I would think, however, that the issue of child poverty, of family violence, of sexual abuse, of family disruption are very key in terms of causing children's mental health problems.

I believe Jeanette Lewis, the executive director of Kinark, whose predecessor is here, spoke very keenly on that, that all of the children in her services were from disrupted homes and that the vast majority had been sexually abused. I think it is incumbent upon us, in terms of our preamble, to make reference to those issues. It might be in just a one- or two-sentence frame, but I think it is none the less incumbent on us.

The Vice-Chair: Would it be helpful, if I might make a suggestion, that there is reference in a more detailed fashion or at least reference to what you are alluding to with respect to this elaboration of these problems within the body of the report?

I have it on page 1. The last sentence reads, "Ninety five per cent of residential patients served by one provider who spoke to the committee had suffered some form of abuse." There was further reference in that paragraph earlier on. So there is reference within the body of the report. In the testimony that we heard, throughout it there was this underlying common theme, that these children came from abused situations and that violence was a problem, etc. I think it is fair to say that we have alluded to that in the body of the report as being certainly a problem and in a more detailed fashion. Is that fair to say, Alison, with respect to that?

Ms Drummond: There are references to it that were raised by the witnesses, especially, and quite a bit of the original background briefing relied on Dr Offord's Ontario Child Health Study, which of course raises a lot of these issues. Yes, it is in the report. I suppose the question is whether it should be in the preamble.

Mr Hope: We are adopting this as a whole report, and as you stated the line above it says 60% of the child welfare clients seek counselling, and in the body of the report the third line up talks about preventive policies which address children's mental health. I think the encompassing of both is that we detected where a percentage of the children come from, so the preamble of the report, the recommendations, would kind of reflect one another, so when we develop policies to try to address the children's mental health problem, we can see that in the body of the report and I think they encompass one another, because it says, "The goal must be comprehensive, co-ordinated and preventive policies which address children's mental health

problems." As we have seen in the body of the report, in the introduction section, the history, just a line above what you read on 95%, it talks about 60% of children of welfare clients seeking counselling or similar services. They interact with one another. I think the preamble just reflects that when we establish preventive policies and look back on the main body of this report, it will tell us that one of the key areas we have to focus on is children's welfare.

1330

Mr Beer: Both the Maloney report and I think Mr Hayday's presentation to us talked about the interrelatedness or the term "predeterminants." I am wondering if we could express the fact that the committee recognizes the interrelatedness, or some kind of wording like that, of both physical and emotional factors, in terms of the principle leading from our desire to raise healthy children. We could mention possibly some of those as well, family stress and a number of issues. I think the concern was simply not wanting to make it appear as though there was just one; it was the way that came forward. If we could have something that stressed the interrelatedness, that kids may face problems because of a whole series of things in different combinations. I am wondering if there is some wording that might help Drummond.

The Vice-Chair: Let me turn to Mr Jackson, and then we will try and get some sort of consensus.

Mr Jackson: Unfortunately, I was going to bring in something new. It is in this paragraph. I simply wish to suggest that I am having difficulty that we are making a statement that we have general agreement that many children are not receiving care in a timely fashion—fine—and appropriate manner. I am having a little difficulty implying that the current service deliverers are not providing appropriate care. That is one way of reading it. I might suggest we put, "and therefore an appropriate manner," where we link access to appropriateness. There was very limited information that there was appropriate programming, and the examples we have addressed, but for it to become a general statement almost is an indictment of the current care givers, and I have difficulty with that. I know it is not the intent, but we are not always going to be here to interpret this. This language is very important as a preamble and principle.

If I can just share with you two more concerns, then I will shut up. This is not a debate. I will share it and if there is no uptake, then that is fine.

The Vice-Chair: Do not make promises that you cannot keep entirely throughout the whole two-hour period, but go ahead.

Mr Jackson: The next concern I have is the reference, "The system must shift its emphasis to helping families raise healthy children." What is implicit is that there was a position which we are shifting from, and I would like to know what that was. If it was the individual child, then I would like to have that more in context. And "helping families raise healthy children" does not imply our definition of families when we know that an overwhelming number of these children are in single-parent families or have been forced to be removed from their parents and are

under foster care or some other institutional care. I have trouble with this definition of "families," when we know there is a correlation to single-parent families. Maybe we can talk about fixing that.

The Vice-Chair: I think "families" means families in general, whether they be single-parent families or two-parent families. It is a generic term for families, obviously.

Mr Jackson: That is what I would hope it says. Perhaps we can strengthen that understanding with language.

My third concern is, "at the same time, the resulting reduced demand for crisis services." I understand that one of the pressures for comprehensive, co-ordinated and preventive policies was in order that the current system be able to meet the existing demand. I could not support "reduced demand for crisis services," because we are not meeting the demand and we are not saying that. Yet that was the genesis of this report: so it will help us to better meet the current demand, in my view, is what this has been all about. If it is not, I am afraid I started these hearings differently. Those are my comments. I think that is closer to what I thought our understanding was.

The Vice-Chair: Can I just point out with respect to that point—then I will move on to other members—that that is to be read with the previous sentence, that is, "the goal must be comprehensive, co-ordinated and preventive policies," which will then imply a reduction in demand for crisis services because of the preventive efforts. That is the intention of that sentence, but if you read it in isolation and take it out of context, then I would agree with you, but it is coming on the heels of the previous sentence.

Ms Haack: I was going to concur with the statement you just made, because I read it that way, that because of these particular efforts we would see a reduction at the other side, the algebraic equation.

I also felt—I do not want to say "strongly"—I am somewhat concerned about the issue of Mr Jackson's earlier comment on "appropriate manner." I consider myself to be really a lay person in receiving the information from these very various groups. I can only say that I feel they have handled things in an appropriate manner. Unless by some chance I were an expert or we had some information by a group of experts and consultants who had done an inventory of the system and could say, "As a professional in the field, such and such a group is not handling things in an appropriate manner," I think we have to stick to the general in that area. The only one of us here that I know of—obviously, I am not completely familiar with all the curriculum vitae on the other side, but I know Drummond has worked in the mental health field and may be able to make some comments. I think for the most part we are very much lay individuals and we have to accept that type of terminology.

The Vice-Chair: Before moving on to Mrs McLeod and other members, I just remind members that we are very pressed for time. I do not want to dwell too much on one point.

Mrs McLeod: I have a suggestion on how we might incorporate the concerns. I think we would agree that we want to avoid making a judgement one way or the other

about appropriateness, for exactly the reasons Christel has indicated. I do not think we are in a position to make that judgement, so if we can find a wording that just takes out a judgement.

On the second part, I would suggest that we might have a sentence to indicate that many interrelated factors which increase stress on families contribute directly to children's mental health problems. Without having to list them all, it would indicate that family stress really is a significant part of the problem.

The Vice-Chair: Is there agreement on that? Let's deal with that and resolve that issue. Let's try and get a consensus on the wording.

Mrs McLeod: If I could just make my next point, which is my last one, it would try to tie in what Mr Jackson was raising as well with that previous point. It might be a way of facilitating it, if it did meet with consensus. You might look, for example, after "in a timely and appropriate manner" at a statement to the effect that: "Many interrelated factors which increase stress on families contribute directly to mental health problems in children. It is therefore essential to provide support needed to ensure that families are helped to raise healthy children." That would remove the shifting of the emphasis, which is a concern for Mr Jackson, and I think appropriately, because shifting emphasis suggests that we are somehow going to take resources away from one area, where we know there is need, and put them in another area, and I think all of us would agree it cannot be either/or.

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The Vice-Chair: I think that is a helpful suggestion.

Mrs Witmer: I can support that.

The Vice-Chair: Can you repeat that?

Mrs McLeod: Do you want me to pick it up from "in a timely and appropriate manner"? The wording will be approximate, because it has been scrawled down fairly quickly.

The Vice-Chair: Okay. Try it again.

Mrs McLeod: "The many interrelated factors which increase stress on families contribute directly to mental health problems in children." You might want to preface that by saying "witnesses in committee agree" or something to that effect. "It is essential to provide support needed to ensure that families are helped to raise healthy children."

Ms Drummond: I think that could be cut down a bit, but okay.

The Vice-Chair: Did everyone follow that?

Mr Jackson: Are we going to get rid of witnesses? "The committee agrees the system must shift its emphasis." We can stress it, but not saying we moved away from it.

The Vice-Chair: We have agreed to remove that.

Mr White: I would like to commend Mrs McLeod and Mr Beer on those points. That wording certainly encompasses my concern.

The Vice-Chair: I think that means we have consensus, so we will move forward. That is agreed to. That clears up the preamble.

Mr Jackson: Mr Chairman, the "appropriate manner" still sticks out. I recommended "and therefore an appropriate manner," so that access becomes the pivotal issue in terms of appropriateness. I still leave out there questions as to the quality of work being done in mental health facilities in its present form, and I will not accept that.

Mr Beer: I think we agreed with expressing that, that it was not meant to be judgemental.

Mr Jackson: Fine. And you accept "and therefore an appropriate manner." Thank you.

The Vice-Chair: We will move on. Next is "Access to and Co-ordination of Services." Any discussion or any relevant points to be raised on that item?

Mr Jackson: I am sorry, Mr Chair, just to finalize it: We are leaving it that the preamble and principles have nothing to do with the waiting list; it only has to do with shifting the emphasis or reducing the demand for crisis services to parental services. We are not acknowledging the notion that we will be able to serve more children, that if we reduce the demand for crisis services we can therefore assist more children in this province. I need to know the answer to that because that stems from the minister's statement that we do not know if we will need more resources. This report would indicate we may not need more resources; we are shifting the emphasis.

The Vice-Chair: I do not think that is what it says at all. I think it is a question of placing a premium on preventive measures so that we therefore would not be in a crisis situation with respect to urgent care. That is a crisis. I think it was acknowledged throughout our hearings that there was indeed a crisis. Therefore, by doing this we will not have a crisis on our hands. I think that is what the intention of that statement was.

Mr Jackson: I challenge that statement, only because we have a crisis now in terms of access. You are suggesting you will reduce the number of people who will need it, but there are still going to be many kids needing the service.

The Vice-Chair: It does not imply that services will be reduced. It will mean that the waiting list will be reduced and as a result, there will be less of a demand for that service. That is what it implies. One does not mean the other. Do you see what I am saying?

Mr Jackson: By removing "shifting the emphasis," I might buy it. But with "shifting the emphasis" and then "reduction," it clearly implies reduced program.

Mr Beer: Your shifting is gone—

Mr Jackson: Has been removed. Yes. I can almost live with it.

Mr Beer: I want to be clear on the subject to my colleagues on the subcommittee that what we are talking about here is that we recognize that there is a problem right now, that there are children waiting for services who ought not to be waiting, and then we try to go on under the

next set of recommendations to begin to spell out how we can deal with that. If we can develop "comprehensive, co-ordinated and preventive policies," we would hopefully reduce the demand for crisis services, but that would mean simply that the system was working better in dealing with kids much earlier in the system before it is a "crisis," and that we do not have the lineups for that service.

The Vice-Chair: Do we have agreement or shall we debate this point further?

Mr Jackson: I do not want to debate it further. I now understand there was a blockage in the subcommittee meeting. I did not have a chance to read all of what constitutes amendments from this morning's meeting. I presumed from day one that there would be an acknowledgement in this committee that we find the current waiting list unacceptable. I assumed that surfaced somewhere in the report. I am now told it is not. Certainly our caucus is having great difficulty that we are not making a simple statement that the current waiting list is unacceptable. Therefore, recommendations and strategies should be positive but at least acknowledge that we find the current waiting list unacceptable. That is why I am trying to imply that the preamble and principles make some reference to what our initial assignment was, which was to deal with the waiting list. There is where my difficulty is, and I am having trouble moving when we seem to not wish to talk in any way, shape or form about the waiting list and/or the impact it will have on our recommendation.

I am prepared to be flexible. I have suggested the shifting of the emphasis will help us better to address the current demand, which we consider to be far too great in this province. I could live with something as simple as that, but not to imply anywhere in this report would be, in my view, a substantive departure from where we believe we should be going as a caucus.

I just share that with you. I know Elizabeth shared that with the subcommittee in very strong words, but we also have to get it on record here as well. You know that is part of the process.

Mr Beer: I think it was our intent to recognize that there is a problem, that there are too many children waiting for service. There might be disagreement about numbers and so on, and one of the things we wanted to get to in the other recommendations is how we go about determining who is waiting and waiting for what. So we would not have any problem with trying to make it clear that we do recognize and must recognize that the current system is not meeting that need.

It is perhaps somewhat oblique, talking about not receiving care "in a timely and appropriate manner" in the context of the list. We could maybe have a look at the wording Cam has suggested in that last sentence, or some such wording. We are saying whether it is 10,000, 6,000, 3,000 or 2, we do not want to have waiting lists if we can avoid it. If there is some way of expressing that concern, then we can do that.

Mr Jackson: Before you move on, Mr Chairman, let me simply say that bullet 3 on funding will constitute a major debate. That will put in context how we intend to

deal, even in the short term, with the waiting list. I am prepared to suggest we move on, as there was consensus—except on that point—so we can get into the meat of the recommendations and get beyond the preamble.

The Vice-Chair: I still have Ms Haeck, to address that same point.

Ms Haeck: I think it would be appropriate to move on, as I am not exactly sure what wording we are talking about. I think we are generally agreed and obviously the minister was quite clear that one child on a waiting list is too many. It is a matter of shifting—and I will use that word—the system so that it deals with prevention and allows a number of other things to take place at the same time.

The Vice-Chair: Mrs McLeod, do you have a suggestion for the wording of that?

Mrs McLeod: Just to try to capture the sense of the concerns that are being raised. In the last suggestion, we were looking at "families raising healthy children." We could go on to include there, "At the same time it is recognized that current waiting lists for children's mental health services are unacceptable. The goal therefore must be comprehensive, co-ordinated and preventive policies which address children's mental health problems. Comprehensive services leading to a reduced demand for crisis services will help everyone."

1350

Mr Hope: Shoot that over again.

Mrs McLeod: Sure. Basically it continues to recognize the family stress, the importance of helping raise healthy children, then says: "At the same time, it is recognized that current waiting lists for children's mental health services are unacceptable. The goals therefore must be," and it is the same line that is before us, stressing comprehensive, co-ordinated and preventive policies.

Mr Jackson: And "increased access for children" at the end, so "providers of those services, parents, and increased access for children."

Mr Hope: You are contradicting yourself, because if I am understanding the preamble properly, the preamble is in a three-phase operation: the current situation, what you have to address in the midterm, and then your end result will be the reduced demand on crisis services. Is that not what a preamble is all about, first of all your initial statement, what is wrong with the system, what the goals should be and what the end results should be? What you are saying is what would be the end result, because in the end result you are saying we have to have more facilities.

Mr Jackson: No. I said that reduced the total waiting list. You want to differentiate the waiting list based on what is preventive and what is acute care.

Mr Hope: No, reduce the demand.

The Vice-Chair: One at a time, because Hansard cannot follow that.

Mr Jackson: For crisis services. Sorry. I think it hits the essence of what we are about, because it deals with the notion that if we accept that the waiting lists are unacceptably high, then we have to ensure that the goal

was that we increase the access for children who are currently on that waiting list. I guess the simplest way of describing it is, as it stands, the way it is presented, it says that of the 100% we are doing now, it may be 80% crisis and 20% preventive. We are now going to shift that to 40% preventive and 60% crisis. I am simply saying that we have to increase both, which does not imply institutionalization, it implies access, that is all, with more emphasis on prevention. Then everybody wins, which is what we say, "Everybody wins."

Mr White: I would agree with some of Mr Jackson's concerns. There are, I understand from the witnesses, some strong concerns about some of the core services which, regardless of the level of primary services, may still be necessary. I think that was clear from Kinark's presentation and I think as well from Earlsclourt's. We do not know what the relationship is between the provision of those primary prevention services and those core services. We do know it should prevent a fair bit of family problems, a fair bit of children's mental health problems, but we do not know what impact it is going to have on those severely disturbed children.

I think it is beyond the wisdom of this committee to make any ironclad statements. I would like to suggest that the last sentence be reworded to, and I hope this would encompass Mr Jackson's concerns, "It is hoped that there will be a resulting reduced demand for crisis services, which will help everyone," as was previously noted here. That way we are not necessarily tying an increase in prevention services to a decrease in those core services for the very disturbed children. There is not necessarily a relationship between those things.

The Vice-Chair: We have a suggestion by Mr White.

Mr Jackson: I could not accept it, because I think, in all due respect, Mr White has it reversed. He has created a linkage in the language that was going forward. I am trying to create separation of that to make sure that in fact we are not looking at a status quo and just shifting the emphasis, that there is some acknowledgement that our actions—and we should have the confidence to know that—are going to produce greater access. That is all I am trying to imply. I feel it must be clarified and not remain silent; increased access for children.

Mr White: I do not think we have accommodation here.

The Vice-Chair: Let's hear from other members before we move on.

Mrs Witmer: I wonder if we could not simply remove this sentence altogether and simply end it with, "The goal must be comprehensive, co-ordinated and preventive policies which address children's mental health problems." That is our objective.

Mr Hope: What is the end result?

Mrs Witmer: The end result, obviously, that we are hoping for is that any demand for mental health services will be drastically reduced and we are not going to have the long waiting list. We will be able to deal with children

as the needs arise. We have our preamble and then our goal.

Mr Beer: On that point, I think it is perhaps something we want to look at. If we are saying clearly in the last part of our principles that we set out our goal, "comprehensive, co-ordinated and preventive," and we then in the body of our recommendations suggest ways to go about doing that, I think the argument we are getting into around that last sentence is a valid discussion but it need not cause problems with the preamble and principles statement. Maybe it would be better, so that we can have agreement, if we just left that last line out and then looked at the other recommendations, which speak to how we seek to go about implementing our goal, because I think we all agree with that goal.

The Vice-Chair: Am I understanding this correctly? There is agreement to remove that last line?

Mr Hope: In a preamble there has to be a start, a middle section and a finish, and the finish is to take away the demand of the crisis. I believe at the same time, and I guess it is the preliminary starting of that sentence, that we need to address that if we achieve the goals, when we achieve the goals of implementing comprehensive, co-ordinated and preventive policies, we will then result in reduced demand for the crisis services and will help everybody provide for those services, parents and children.

Mr Jackson: We just cannot live with that. We find it discriminatory. If the goal cannot be that all children who require the service have a fair and equal shot at getting help, we cannot put our name to that report. It is that simple. It is a form of discrimination based on who gets on the list and how they get moved on the list. I know we have not spent much time on it, but I will not and we cannot endorse something that implies that we are just reducing a certain form of demand within a large problem.

Mrs McLeod: I would like to suggest that even without the last sentence, I do think the sentence about comprehensive, co-ordinated and preventive policies addressed the issue that Mr Hope was raising, because I think the preamble begins with the concern that we are not dealing adequately with children's mental health problems, goes on to recognize that in order to address children's mental health problems adequately we also have to deal with family stresses and that the comprehensive co-ordinated approach is our way of dealing both with the waiting list and the family stresses that are contributing to the children's mental health problems that we identified in the first line.

I think the fact that we are emphasizing in our last statement—it would then be the last statement—comprehensive, co-ordinated and preventive policies takes us very directly into the body of the recommendations and that the real achievement of our committee will be to say, "This is a new direction that we all agree is essential and we recommend a task force to look at implementation."

Mrs Witmer: I know you are aware of it too, but it is the time I am concerned about. We are only dealing with the preamble. I wonder if we could have a show of

hands showing some consensus, go on with the recommendations and then come back and make sure we are all comfortable once we take a look at them, or we are not going to get finished. I do not know how we will deal with it then.

Mr Hope: Why do we not deal with the recommendations we agree on?

The Vice-Chair: That is perhaps a useful suggestion, that we move on to deal with the rest of the recommendations. Then we will come back to any contentious points. The clerk reminds me we can vote on any contentious points that we have at the end. So shall we move on then to the next part of the recommendations, which is "Access to and Co-ordination of Services"? Do we have agreement on this part of the report? Any discussion? No. Let's move on to funding, on the next page. Can we move on? "Research, Evaluation and Training."

1400

Mrs Witmer: I had put this position forward in the subcommittee and it is number 3. I believe that if we are ever going to reduce the number of urgent cases on the waiting list, which according to the research that we have been shown is about 10,000 children, there does need to be an increased amount of funds provided to help these children who are most in need of service at the present time. So I would like to see in bullet 3 that "the upcoming provincial budget provide additional funds," meaning more than what is presently being provided, "to enable the children's service sector to address the most urgent cases on their waiting lists," because it is fine, we are going to do this study, we are going to have a task force. However, we need to deal with those children now. Those children cannot wait for a year or two years from now. Their needs need to be addressed at the present time and it is going to require more money.

Mr Hope: I think the wording put forward is adequate. What we found out in the previous administration is that we just keep dumping money into a problem without taking a proper analysis of the problem. In the long term, out of the analysis that we do in trying to come up with a resolution to the situation, we may need more funds. But whether it be more funds or equal funds or whatever, and it probably will be more funds, providing adequate funding for children's services is one of the keys.

Mr White: I certainly agree with there being urgent cases on the waiting list, but specifically targeting becomes problematical, seeing we have spent half a page on recommendations about access and co-ordination and planning. We are prejudging the outcome of that discussion from the very service providers and consumers, who are much more familiar with these issues than we are.

Mrs McLeod: I think that Mr Hope's point—and I am sorry that Mr Jackson has left at the moment, because I think it addresses the essential conflict that was emerging in our discussion about preamble, and that is the inclination to make a judgement that there are not appropriate services being delivered by children's mental health centres.

I really cannot concur with any suggestion that there has been a problem with simply dumping money in and

therefore they do not need more money. I really do not believe that was an indication, a judgement, that this committee could make based on the testimony that we heard from witnesses. If anything, the testimony would lead us to exactly the opposite conclusion, that there was a tremendous shortage of resources even to deal with crisis situations. Again, I believe it cannot be either-or. We cannot say that because we are going to recognize the importance of preventive programs and primary programs we can therefore ignore the fact that there are long waiting lists of crisis situations without resources adequate to meet those needs. I would be very concerned about a report which attempted to make this an either-or situation.

The Vice-Chair: Can I then conclude from this that there is not a consensus on that statement? Should we set it aside, Mrs Witmer? Can I just conclude that we do not have agreement on that, or would you like to hear further debate?

Mrs Witmer: Yes, I would appreciate hearing further debate. I am not quite sure why people are reluctant to provide those additional funds. We certainly heard from the witnesses the fact that such things as pay equity and the employer health tax and the additional security measures that they were taking for their own staff were forcing them to use those much-needed financial resources to pay for those type of problems, as opposed to directing the money to help with the children who were desperately in need of services. They have not been reimbursed. That money has been taken away from them and they have not received any additional funds. This is the type of additional funding that I believe should be made available to them this year. If this government is truly concerned about children and the mental health of children in this province, I think it needs to be prepared to provide that additional money that has been taken away from providing actual service to children.

Mr Owens: It is unfortunate that Mrs Witmer has framed her comments in the manner that she has, of pairing the level of care with the dollar value that this government decides to put into children's mental health services. I think that is a very unfair comment.

Second, I do not think it is within the jurisdiction of this committee to order the Treasurer to commit funds, and while we do take this as a serious issue, I think that we should leave it up to the Treasurer and the Minister of Community and Social Services to work out the when and the where and the how that funding will be granted to these services. You suggested, Mr Chairman, that this should be left aside as an issue for voting as a contentious issue.

The Vice-Chair: I am prepared to.

Mr Jackson: Would you clarify the question, just to correct his assumption that this committee cannot order up and recommend matters that impact the Treasurer. In fact, we very much can.

The Vice-Chair: It is only a recommendation.

Mr Jackson: Precisely. I just was hoping you would correct that.

The Vice-Chair: That can happen.

Mr Jackson: That is what I am saying. Mr Owens's assumption was that they could not, and I just wanted you to clarify for him that it is very much within our mandate to recommend expenditures, because it is not legislation we are dealing with, it is not private members' time. It is in fact simply an expression of our beliefs and feelings after having listened to input that is very focused on this issue, perhaps better than the minister has been able to get in the short time she has been the minister.

The Vice-Chair: That is why I suggested that we set that aside and deal with it on a vote.

Mr Jackson: I could not accept it in its present form, Mr Chairman, because it is as much as saying, "On an annual basis the Treasurer shall submit a budget." It is telling the world something we already know. Moneys are in the budget for children's mental health, there will be next year and there will be the next year. I could not support something which just simply reiterates the fact that the province continued to show somewhere in the budget moneys allocated for children's mental health. That is like stating Tuesday follows Monday. So I think it is a waste of time putting it in the report.

The Vice-Chair: Would members like further discussion on this item, or shall we move on?

Mr White: Move on.

The Vice-Chair: We will put that aside and deal with it later. Can we move on to "Research, Evaluation and Training," that subheading? Any discussion or debate, points of interest?

Mr White: Just a couple of very small points. I am wondering if it could not be added either as a bullet here or as an addendum to the last bullet on the previous area that there be encouragement through funding mechanisms to children's mental health centres that are currently or planning to be involved in both research and program evaluation, so that we can in fact, as Dr Offord suggests, know when we are doing more good than harm.

The Vice-Chair: Just for clarification, you would like to include that in one of the bullet points here.

Mr White: That is right. It would be specifically targeted money for children's mental health centres.

Mr Beer: I am just wondering, Mr Chair, whether we might, on the last bullet, under funding, say, "funding incentives be given to encourage agencies to co-operate in the provision of local projects and to develop research and evaluation projects or programs."

Mr White: I think that is an excellent idea, especially if they are co-operating in providing that service. Then you do not have a suspicious research program where you are evaluating yourself entirely. Excellent suggestion. It certainly agrees with me.

1410

Ms Drummond: So is there consensus that this might be a little bit more appropriate under the last bullet, under funding, which would then read: "funding incentives be

given to encourage agencies to co-operate in the provision of local projects and to develop research and evaluation?"

The Vice-Chair: Do we have agreement on that?

Mr Jackson: Only one point. It is rather incestuous that the local projects are evaluated by themselves. It is tradition in this province that they be either co-operatively evaluated—I only introduce that because this is a complex issue, and although we support the notion of evaluation generally, the evaluation is by the government to ensure that it conforms to the provincial goals as set out by the minister and her ministry.

I think it was fine the way it was. I think it is presumed that you were to be evaluating, but no one really spoke about it; they mostly spoke about financial carrots and incentives. I think we have caught the point, but I do not wish to imply that we are checking our own evaluation systems because quite frankly, it is not done that way. It is done by external or it is done by the ministry.

Mr White: I would just like to differ with Mr Jackson on that score. My own understanding is that there is darn little outside evaluation done. Mr Goldberg from Earlscourt went into some detail about the program evaluation and his program. I believe that rather than being something which was entirely in-house, as Mr Beer suggested, if we are funding as a co-operative project among children's mental health centres, it would be to some degree removed from that particular centre. I think this, to some degree, answers Mr Jackson's concerns.

Mr Beer: Would it help, Cam, if we made it a separate point because I was not intending—

Mr Jackson: We could put it down below.

Mr Beer: —to link the local projects and the research, but just if you wanted to keep it within funding, we could say—

Mr Jackson: No, I do not. I want to move it into research. That is a smart place to put it.

Mr Beer: Into research, as another head?

Mr Jackson: I get hung up on money on evaluation when you really want to just simply impose a standard that the good work should be evaluated. It should not be encumbered with funding because that is an internal ministry thing.

The Vice-Chair: I think we have an agreement. I see heads are nodding.

Mr Beer: I was just saying whether it goes under "funding" or under "Research, Evaluation and Training." I mean I can see ways of wording it. In either case, I think it is a good point that we would like to see more done in terms of research and evaluation, which I think was the intent. If we can get agreement on doing more of that by placing it under the Research, Evaluation and Training heading, then I have no problem with that.

Mr White: I suggested to you earlier in terms of underfunding because Mr Beer very generously offered a suggestion along those lines, wherever the committee might agree to put it.

The Vice-Chair: Can I conclude that we have agreed to put it under "Research, Evaluation and Training"?

Ms Drummond: Okay. And the possible wording, using the same wording as the last bullet under funding, "Funding incentives be given to encourage agencies to participate in research and evaluation"; is that acceptable?

Mr White: Shall we leave in the phrase "co-operatively"?

Ms Drummond: Okay.

Mr Owens: One more point under "Research, Evaluation and Training," the third bullet point, after the words "with respect to," then add the word "accredited."

The Vice-Chair: I see. "With respect to accredited programs"?

Mr Owens: Right.

Mr Jackson: What does that mean?

Mr Owens: I will pass that question to my colleague, Gary Malkowski.

The Vice-Chair: Mr Malkowski to clarify that point.

Mr Malkowski: The reason for adding the accreditation is that programs are offered at both the university and college level and we wanted to make sure the programs that are being offered are of quality substance and updated as well.

Mr Beer: A question to those who know better than I: are there some sort of, you know, perhaps training programs or others that one might take which do not necessarily lead to some kind of a diploma or degree? We wanted to make this to cover developing programs, and I just would want to be careful we are not limiting ourselves, but perhaps there is an answer to that.

Ms Haec: I strongly support the addition of the word "accredited" for a couple of reasons. One, although Mrs McLeod, I know, is aware of the community college and university system, there are sometimes programs that could be run, say, in a continuing education mode which, while they in fact address a certain need, at the same time, from a professional point of view—and we do realize that within the health disciplines there is a whole debate going on at this present time about accreditation—I think we do have to insert the word "accredited" to make sure that we are not going to end up hamstringing people when they are trying in fact to do the right thing of upgrading themselves.

Also, as a librarian, I have been in the situation where the university program that was at the University of Ottawa around librarianship had to be dropped because it was not in fact accredited by the American Library Association, which in fact does the accrediting for all library programs across this continent. So you could find yourself having people enter programs where, because they are not accredited by the appropriate professional body, the people who have now received those particular diplomas or degrees, whatever, find themselves in an unaccredited status.

Mr White: I am sorry we had not addressed this earlier. It is something of a quandary because I think that, for example, in the schools of social work,

programs are initiated long before they are accredited, usually several years, and I would like to make reference to one particular school which has been particularly innovative in northern Ontario and the near north. That is Laurentian University, which has a bilingual masters program, and in fact Mr Barbeau, who was a witness here, said all of his workers are participating in that program. That is a major assist to the francophone mental health services in northern Ontario. I doubt it would be as yet accredited. Laurentian also offers a native BSW program, which probably is not accredited either.

While I think that accreditation is a major issue, the development of programs usually, the most innovative aspect of that development, occurs before they are accredited. So I think we would have to accommodate both those issues.

Mrs McLeod: I wanted to address what I think was the concern that Mr Malkowski was raising with the question, which was the quality of the programs that would be offered, and suggest that because it is recommended here that we look at college and university programs, those are programs being offered by accredited institutions. I believe that there is some measure of certainty about quality because of that.

I would hesitate to see our committee get into the issue of professional accreditation, which I think is the one that Ms Haec was raising, because that takes us into a whole other field that the committee was not, I think, intending to get into and could in fact reduce our recognition that a workshop is an appropriate program for a college or university to offer without its ever being accredited by a professional body but nevertheless being important. I really believe that Mr Malkowski's concern is met by the fact of the college and university settings for programs.

Mr Malkowski: What that means is, you are suggesting, with accreditation, the colleges and universities could simply invent their own program. I am not sure what kind of a program that would be and that could certainly damage the reputation that is involved with a college or university.

1420

Mr Jackson: The first obvious point is that this matter was not raised before the committee at any time, to my knowledge. What was raised before the committee has been dealt with in the recommendation that is before us, and again it has less to do with the professional credentials and academic base, but more that access to programs allows for groups that are highly discriminated in this province by geography and by cultural origin to improve their access to programs.

I am very comfortable, not getting into the Ministry of Colleges and Universities bailiwick here, simply indicating that we support that programs should be based from the colleges and universities and that we have seen some deficiencies in access for professional people which should be addressed. I think putting "accredited" in there puts in a whole new emphasis, unintended emphasis. I might support Mr Malkowski with his suggestion, but I think it is premature to the report and not in the spirit of the point we

are trying to stress here, which is access for groups that have not previously had access to these programs.

Mr Beer: I am wondering if this will help. What we are doing here is recommending that the Premier's Council on Health Strategy look at a number of issues. I think people will recall that there is this whole issue of social services providers and how ultimately they should be licensed, and all of those attendant issues. I am just wondering if what we are saying here, and I think Cam is correct, that we were seeking, through the discussion, to find ways to expand the programs that are offered because we recognized that there were limitations.

I think from our discussion, and in the work that the Premier's Council on Health Strategy would do, in looking at what kinds of programs exist or ought to exist, would come as well questions around the nature of those programs, whether or not they are accredited. I just did not feel at this point in time that we wanted to limit them only to that, in that I think there may well be arguments to have programs even to do the sorts of things that Drummond has spoken to. I am just wondering if we are not better to leave it the way it is, noting that it is a recommendation to the Premier's Council, out of which, if they did their work, would come a report which one could then deal with.

Ms Haeck: I am interested in the direction that the discussion is taking, but I do beg to differ with Mr Jackson in particular because some of the earlier drafts of these recommendations very specifically talked about master of social work and PhD programs at institutions. If you are talking about programs at that level, you are talking about professional accreditation. So it is a different matter entirely than how it has been synthesized here.

I did overhear behind Mr Jackson, between Mr Beer and Mrs McLeod, a discussion about internal institutional upgrading. I personally do not have any problem with that. Maybe there is a way of expanding some of that, not limited to accredited programs. We encourage the various centres out there to carry on professional development within their own walls. I personally am very much in favour of staff development, so that is really not an issue. But I am concerned about some of the debate that has been going on in the health disciplines around some of these issues. In one sense I do not want to end up finding ourselves, as a result of that, carrying on much further a more heated debate.

Mr White: I was just going to comment that I thought Mrs McLeod's suggestion and compromise was a very creative one. It is unfortunate it does not look like we will be able to use it, though.

The Vice-Chair: I am trying to get some sense of where we are headed with this.

Mrs McLeod: Can I just plead guilty to being the one who was first much too exclusive in suggesting specific professional programs? They happen to be ones that I have been advocating for some time. They are ones I am aware of in terms of the need and the preparation for those programs. But I was the first to agree that it was much too exclusive and that this broader category allows for both that and the broader scope of programs.

I intend to continue to push for some of the more specific programs that I believe in.

Mr Jackson: A major cost item to the government. I do not know why we would be suggesting anything other than what the NDP has recommended. This puts incredible pressure on the Minister of Colleges and Universities at a time when there is gross underfunding, so technically one should want to push it. I read it as a discriminatory practice for access to professional services and in my view, you cannot talk about native groups in this province and talk about MSW and BSW because only 1% or 2% of native children in this province ever see the inside of a college or a university classroom and I cannot help but think that was the plea from the group that stressed it the most.

The Vice-Chair: I do not, from this discussion, gather that we have a real consensus on this. You can live with this?

Mr Jackson: We can live with it. Our concerns are on record.

The Vice-Chair: As it is right now, Mr Jackson?

Mr Jackson: This is not a big thing. It leaves a gap in what I thought we were addressing and if the government can live with that, fine.

The Vice-Chair: I just want to get further direction for our research officer. We will leave things as they are, is that the understanding now? Agreed? Okay. We have agreed to include, under "Research, Evaluation and Training", program evaluation. That is the gist of it. Can you clarify that?

Ms Drummond: Okay, I gather there was a consensus to add finally under this section, "Research, Evaluation and Training", so that we can finish with it, an additional bullet point to read "Funding incentives be given to encourage agencies to co-operate in research and evaluation."

The Vice-Chair: Agreed? Okay. Native issues. I am reminded by the clerk that we have approximately 18 minutes left so we do have to speed things up before we start to vote on these other items.

Mrs Witmer: On the section related to the native issues, the second bullet says that the ministry make a financial commitment. I guess the question I have here is, why are we making this statement? Is there not a financial commitment being made at the present time? Are we asking for more of a financial commitment? Why do we include that? I am wondering if some member of the committee could help me to understand.

The Vice-Chair: Mr Beer, do you want to comment on that or shall I turn it over to our research officer? When in doubt, turn it over to the research officer. The question was asked by Mrs Witmer.

Ms Drummond: Your question was whether there is a ministry commitment to native mental health services.

Mrs Witmer: I am wondering why we have made this statement. Is there presently not a financial commitment being made?

The Vice-Chair: At the present time.

Ms Drummond: There is at present some financial commitment, yes.

Mrs Witmer: So we are simply reaffirming that, I guess. Why is this statement here? Maybe one of the other members can tell.

Mr Beer: I think the point, and it may need a word or two, was that in the last number of years the Ontario government has sought to work with specific native organizations around a broad series of children's issues and so we developed Tikinagan, Weechi-It-E-Win and some others that are providing services not unlike children's aid societies. But in developing, and I think it was implicit in the comments made by the Tikinagan group, it was specifically looking at native mental health services and there was a direction previously, and I would assume there would be in the future, to focus even more so on native mental health issues. Indeed, some of those native children's services organizations could well develop to provide a broad range of services, including native mental health. My sense in this one was that we just wanted to make clear that this is an area where there is a lack of adequate service for the native community.

1430

Mrs Witmer: Just in response, does this mean that the ministry is going to have to put more up money? Will they need to make more money available? Is this what we are saying? I guess I want to know, is it because of lack of money?

Mr Martin: I would suggest that certainly anything I heard from the folks who presented here as witnesses was that they needed more resources to do more work, which is people, and to do it in a way that they saw as appropriate. Certainly it would be assumed under here that there would be more money going in. It is just a matter of where it comes from and how it is delivered. I think we need to be creative and resourceful in how we do that. Ultimately my assumption is that it probably will need more money. There is an assumption by me in that the ministry will find, however and wherever, the resources necessary to make this recommendation happen.

Mr Hope: Just to address Mr Jackson's point of view when we were talking about accredited programs and just on the other one, on "Research Evaluation and Training", I was not the one who put this in, but just reading it, it talks about developing native mental health professionals, which means you have to provide funds to help them get into the educational field. This was one of your comments you brought up earlier on the previous one, to provide funding to help natives access the educational field to become professionals.

Ms Drummond: If I can just quickly address, or partially address anyway, Mrs Witmer's concern, the wording is a little bit vague because as we discussed in the subcommittee there are some really complicated jurisdictional issues. Some native groups have not always been willing to accept funding from the provincial government. Possibly the verb "to develop" rather than "to establish" would clarify some of your concerns.

Mrs Witmer: I guess I am wondering whether we are going to be providing the same resources or whether we feel there is a need for additional financial resources.

Mr Hope: I think the key is that you are developing a new identity in itself and then the identity would be the health professionals. Through the presentation, it was talking about getting more natives, and Mr Jackson brought it up just a little while ago, about helping the natives access programs to come out professionals to work in the mental health field. I was not part of the discussion, but just reading it, it says "develop native mental health professionals." I think the funding aspect has to be in there for access.

Mr Jackson: I think where we are getting into difficulty is that if we leave it the way it is, it implies that somehow these programs are at risk unless we make a commitment, and I do not think that is fair to the current nor the previous government. Having said that, there is a distinction between native mental health services which have been established and are being funded. Their presentation to us said, "We are a native service in name only and until you get us native trained professionals, we really cannot be, so we can implement our own healing methods."

I think the flaw in the way this is written is that we are talking about funding for something that is existing and something we want to move towards. They should either be separated or one of them dropped. I think if we are looking at to continue, we support the current program and we are looking for expansion dollars for increased native mental health professionals and for training. That is where I see the problem in this right now, but I find it says nothing to say we should make a financial commitment. There is one for the centres. What we are looking for is new moneys, targeted or focused funding, for the development of native mental health professionals.

The Vice-Chair: I do not feel we are that far removed from gaining some kind of consensus. I am going to turn to Mrs McLeod, who I hope will come up with a good suggestion to wrap things up here.

Mrs McLeod: I am going to try to be helpful because I think the problem is that there is a different jurisdictional aspect for different parts of the statement, one being mental health service, another being training opportunities, which could be entirely provincial, if we chose to see it that way. My suggestion would be a simple rewording, that "the ministry make the necessary financial commitments to develop further..." It does not make any presuppositions about what does or does not exist or where the funding should come from.

The Vice-Chair: Can you repeat that one more time so that everyone is clear?

Mrs McLeod: "The ministry make the necessary financial commitments to develop further native mental health services." It is too bad that split infinitives often work better.

Ms Drummond: We can work out the wording if there is a consensus on the meaning.

The Vice-Chair: We have agreement. Let's move on to the final segment. We have only four or five minutes left

to deal with this, "Language and Culture Issues." Do we have agreement on the two points that are made there?

Mr Jackson: Did we hear of minority-language programs? Did we hear about several of those?

Mr White: Yes.

The Vice-Chair: We have agreement.

Mr Hope: Just to clarify some of the points that were talked about as far as the funding is concerned, and we talked about the wage problem, the pay equity problem, it is indicated in the funding aspects. If you look at the whole funding recommendations, they talk about only one thing, to establish more money, not necessarily does the—

The Vice-Chair: Can I just interrupt you? I want to deal with the preamble section first.

Mr Hope: I thought he said more funding.

The Vice-Chair: I would like to deal with the preamble, vote on that and then move to the funding.

Mr Hope: I chaired this meeting, eh?

The Vice-Chair: There is no time for further debate, as I am reminded by the clerk. We need to move to the preamble section. Is it the intention of the committee to include the last sentence in that preamble section?

Mrs Witmer: Could she read the new preamble and principles.

Ms Drummond: The new preamble and principles in toto?

Mrs Witmer: As we revised them today.

Ms Drummond: "Many of the witnesses who appeared before the committee provide care to children who have developed serious behaviour problems and other emotional disturbances; there is general agreement that many children are not receiving care in a timely and therefore appropriate manner. The many interrelated factors which increase stress in families contribute to mental health problems in children. It is essential to provide support needed to ensure that families are helped to raise healthy children. At the same time, it is recognized that waiting lists for children's mental health services are unacceptable. The goal must be comprehensive, co-ordinated and preventive policies which address children's mental health problems. Comprehensive services leading to a reduced demand for crisis services will help everyone, providers of those services, parents and children."

The Vice-Chair: Do I have agreement to include those changes, to include that last segment? In particular the last sentence was the contentious point there which we did not have agreement on previously. Everyone has the gist of that. We can repeat it one more time.

Ms Drummond: "Comprehensive services leading to a reduced demand for crisis services will help everyone, providers of those services, parents and children."

1440

The Vice-Chair: We must move on and take a vote. There is no time for further debate. Do I have agreement to include the preamble, as amended, in its entirety? All those in favour? All those opposed? Okay, that is carried.

"Funding," bullet 3: Is it the wish of the committee to maintain the current reading of the bullet point?

Mr Jackson: "The upcoming provincial budget provide." That one?

The Vice-Chair: Yes.

Mrs Witmer: I would like to suggest that we make it consistent with the native issues, that we "make the necessary financial commitments."

The Vice-Chair: I cannot entertain any further debate.

Mr Jackson: That was an amendment, Mr Chairman; it was not debate.

The Vice-Chair: I am entertaining a motion for the current wording to be accepted or not to be accepted.

Mr Jackson: So you are not accepting amendments?

The Vice-Chair: Not at this point.

Mr Jackson: We request a recorded vote on this.

The Vice-Chair: Okay.

Those in favour of the current wording? Mr Martin, Mr Hope—

Interjection.

Clerk of the Committee: That was the question. It is the vote—

The Vice-Chair: I am asking for a vote. Mr Hope, you are voting in favour of that?

Clerk of the Committee: Mr Martin.

The Vice-Chair: All those opposed?

Clerk of the Committee: Mr White has not voted. He cannot abstain.

The Vice-Chair: You cannot abstain, Mr White.

Mr Beer: On a point of principle perhaps, Mr Chair, I think what we are doing is saying there may be another way of wording this which is consistent with the wording we selected in the case of another recommendation, but you are saying we have to defeat this in order to consider that. Am I right?

The Vice-Chair: Right.

Mr Beer: But my point is, there was a change to another recommendation and the consistency of the wording on that would be quite appropriate here, but I am trying to understand how do we get to that different wording.

The Vice-Chair: I cannot entertain further debate, so what I have suggested is—

Mr Beer: That is why I said a point of principle.

The Vice-Chair: Okay. It was suggested by Mrs Witmer originally—I will do this very quickly—"that additional funds be provided." Now all I am saying is that you either accept what is there or you do not accept what is there. Right?

Mr Jackson: That is correct, and by defeating it, would you then accept our recommendation for additional funds, because you would be left with nothing if it is defeated?

The Vice-Chair: You can bring that forward.

Mr Jackson: So by voting against it you would be facilitating the phrase "additional funding." That would be an understanding at the table at this moment.

The Vice-Chair: We need to have a motion to put that forward at the time. Okay?

Mr Jackson: Yes.

The Vice-Chair: But we are voting now as to whether this stands.

Mr Jackson: A recorded vote on support for the wording in front of us.

Mr Hope: You could have—

The Vice-Chair: Can I have some order, please. I am going to ask one more time. I put the vote to you. The current wording in place right now. Is that agreeable to members of the committee? We are going to have a recorded vote.

All those in favour?

All those opposed?

Mr Martin, Mr Hope, Mr Drummond, Ms Haeck, Mr Owens, Mr Malkowski, Mrs—

Mr Malkowski: I am not understanding it. For clarification, do you mind if people were to vote again, please?

The Vice-Chair: We have a vote on the floor to determine whether the current wording stands as is, period. Can I just get clarification from the clerk? We need now a motion to add the desirable wording to this.

Clerk of the Committee: Not until you determine whether they want it or not.

The Vice-Chair: Okay, if they do want it, indeed, they must put a motion forth, so we can entertain a motion at this time.

Clerk of the Committee: No, not until you have completed the vote on whether the current wording stands or not, ayes and nays.

The Vice-Chair: Okay. Have we done that yet?

Clerk of the Committee: No, we are trying to and Mr Jackson asked for a recorded vote.

The Vice-Chair: I thought we did.

Clerk of the Committee: We tried but we have only got halfway around the room. We got stuck at Mr Malkowski.

The Vice-Chair: Okay.

All those in favour?

Mr Jackson: Of what?

Clerk of the Committee: Of the current wording as written.

Mr Jackson: We voted on that three times.

The Vice-Chair: Mr Malkowski abstained, so we needed clarification.

Mr Jackson: I am sorry, Mr Chairman, but even if Mr Malkowski changes his vote, it does not change the vote outcome.

Clerk of the Committee: Mr Jackson asked for a recorded vote. We have not completed the recorded vote.

The Vice-Chair: Did you hear that, Mr Jackson?

Mr Jackson: I heard it, but I did not see it.

Mrs McLeod: Can I just ask, as a point of order, is there a rule for a committee that we cannot deal with the minutes? The wording that has been proposed is, I think, normally a legitimate amendment to the resolution. It does not significantly change the resolution and it would be easier to vote on an amendment.

The Vice-Chair: I will turn to the Clerk for clarification.

Clerk of the Committee: You have to have something to vote on, and the status, as is, is usually where the question is put on at the moment. If you can proceed and vote in favour or against the current wording and then move on to what the proposed change might be, that is the cleanest way of doing it.

Mrs McLeod: It is different from normal parliamentary procedure, then, what applies in committee?

Clerk of the Committee: If you are moving an amendment on a bill, you are moving an amendment to a section of a bill. There is not a section here. There was debate. There was no consensus on it. So at the end of the debate on this particular amendment there was no consensus and it was whether the current wording should go or whether the changed wording should go. So you have to vote on one or the other. You cannot vote on both at the same time.

Mr White: On a point of order, Mr Chairman: We seem to be in the midst of a recorded vote. If we have any further discussion, I think that invalidates our vote, or certainly holds it in strong question.

The Vice-Chair: We are trying to get clarification in terms of the actual—

Clerk of the Committee: We are eating up the clock.

The Vice-Chair: Can I move forward? I called for a vote. We were in the middle of a recorded vote. I asked for those in favour and no one was in favour, and now those opposed—we were in the process of doing that—please raise your hands.

The committee divided on the current wording of bullet 3, which was negated on the following vote:

Ayes—0

Nays—11

Beer, Haeck, Hope, Jackson, Malkowski, Martin, McLeod, Michash, Owens, White, Witmer.

Clerk of the Committee: Now, the alternative wording.

The Vice-Chair: Do we have a motion for alternative wording?

Mrs Witmer moves that we indicate that "the upcoming provincial budget provide the necessary additional funds to enable the children's service sector to address the most urgent cases on their waiting lists."

The Vice-Chair: All those in favour?

Mr Jackson: Recorded vote.

The Vice-Chair: Please indicate. Mr Martin, you have to vote on this.

The committee divided on Mrs Witmer's motion, which was agreed to on the following vote:

Ayes—11

Beer, Haeck, Hope, Jackson, Malkowski, Martin, McLeod, Miclash, Owens, White, Witmer.

Nays—0

The Vice-Chair: Okay; unanimous. Is it the wish of the committee for the report to be tabled and be debated and a response asked of the minister? Those in favour?

Mr Beer: On a point of order, Mr Chairman: Were you going to ask if there were a couple of points on the introductory part that we had raised in subcommittee?

The Vice-Chair: We have no time.

Mr Beer: There is one statement that was raised in subcommittee, that was agreed to in subcommittee.

The Vice-Chair: Do we have time to read them in? Can I call for a recess? Stop the clock.

The committee recessed at 1449.

1450

The Vice-Chair: Is it the wish of the committee that the report be tabled and debated and a response be asked of the minister? Is that an agreement?

Mr Jackson: Yes. Agreed.

The Vice-Chair: We have agreement. Tabled and responded to. Great.

Mr Owens: On a point of clarification in regard to the colleague to my right that you keep referring to as Mr Drummond: Could we have his name corrected as Mr White to ensure that Hansard is correct?

The Vice-Chair: Ms Drummond and Mr White. Sorry. Did I do that?

Mrs Witmer: No, I did.

The Vice-Chair: I thought I had it all straightened out.

We are recessed until 3 o'clock, at which time we will begin hearings on the next item on the agenda.

The committee recessed at 1451.

1506

ORGANIZATION

The Vice-Chair: Call the committee to order. I wish to bring to the attention of members of the committee that the subcommittee agreed that the committee schedule be changed as follows: Wednesday will become a subcommittee meeting at 1 pm, Thursday at 2 pm the entire committee will be meeting to approve the final report, and Friday's meeting will only be held if necessary. Everyone make that change.

Ms Haeck: Excuse me. Friday does present a couple of problems for me personally. I was just wondering what can be done there.

The Vice-Chair: As I say, it will only be held if necessary.

Mr Beer: Christel, we will make sure we agree on Thursday. I have a problem on Friday too.

The Vice-Chair: It will be a further incentive to come to a conclusion on this rapidly.

Mr Jackson: What will be helpful? Is there a time of the day that is particularly bad Friday?

Ms Haeck: I have at least three appointments between 10 o'clock and 3 o'clock.

Mr Jackson: Are you the subcommittee rep?

Ms Haeck: No.

Mr Jackson: Okay, thank you. I appreciate that.

The Vice-Chair: I have been reminded by the clerk that the subcommittee agreed originally to the Friday, and therefore we have to move with that as well unless we are prepared to make further amendments in terms of time and reschedule, but we cannot sit beyond Friday. We have to keep that Friday date open to us for that possibility. It is more of a reserve date than an definite date.

Ms Haeck: In all likelihood we will be using it, right?

The Vice-Chair: I would think that possibly on Thursday we will be wrapping things up and not come back here.

Clerk of the Committee: We could also meet later than normal on Thursday.

The Vice-Chair: That is true. We can extend our sitting time on Thursday after we have met initially, come back and meet at a later time on Thursday. That is another option. Why do we not just leave that and see how that comes about on Wednesday? Can we do that? All right?

Mr White: I am sorry, could I have a review of the changed times, please?

The Vice-Chair: Yes. The subcommittee will be meeting on Wednesday at 1 pm. The full committee will be meeting on Thursday at 2 pm to approve the final report, and Friday will be held in reserve if that day is necessary.

Clerk of the Committee: Or maybe later on Thursday.

Mr Jackson: I was just going to ask what amount of time is potentially left, starting at 2 o'clock on Thursday?

Clerk of the Committee: Originally they had two hours for Thursday and an hour for Friday. That is changing, and we will have to see exactly how much time there is at the end. There has been one addition to the original agenda, and I understand there may be another addition to the agenda, which knocks another hour off the report-writing time.

1510

The Vice-Chair: Mr Owens, you had something that you wanted to raise.

Mr Owens: Yes, I have two items of business, Mr Chairman. The first is with respect to the previous item that we were discussing, the children's mental health report. I would like to make a motion that the subcommittee meet to verify the changes to the children's mental health report.

The Vice-Chair: Is there agreement on that? The members of the subcommittee to meet to verify the changes that have been made to the previous report. Okay.

Mr Owens: The second item of business is that after discussions that I have had with the other two members of the subcommittee, I would like to request that the Ontario Public Service Employees Union be able to testify at these hearings.

The Vice-Chair: Is there agreement on that? All right. The clerk will make a note of that. OPSEU, 4:30 Tuesday. So we will be sitting until 5 o'clock tomorrow at least.

Mr Jackson: Could I simply ask if there were other requests besides OPSEU?

The Vice-Chair: The clerk informs me there have not been.

Mr Beer: There was the one, the Federation of Ontario Facility Liaison Groups, but we dealt with that in the subcommittee earlier this last week.

SERVICE MANDATE FOR DEVELOPMENTALLY HANDICAPPED

Consideration of the designated matter, pursuant to standing order 123, evaluation of service mandate for individuals with developmental handicaps—multi-year plan.

The Vice-Chair: We now turn to the minister, who has been patiently waiting for us to commence our next set of hearings. I will call on her to make her comments. The Honourable Zanana Akande, welcome to the committee again.

MINISTER OF COMMUNITY AND SOCIAL SERVICES

Hon Mrs Akande: Good afternoon, everyone, and thank you for the opportunity once again to come today to speak to you about the multi-year plan.

I want to begin by reiterating and emphasizing this government's commitment to improving opportunities for the developmentally handicapped to live and to work in the regular community. Certainly this commitment is in agreement with the government's social policy to create an Ontario that is a supportive environment for all those who live within it.

Actually, the developmentally handicapped living within the regular community is not a new idea. It is not something that was invented by this or any other government. It has existed before without plan. There have always been isolated incidents, often in smaller and more basic and, therefore, more cohesive communities where the developmentally handicapped have lived in the community. I am not always certain that they have extended the opportunity for them to be involved in everything, all of community life; nevertheless, there have been isolated incidences where this has been true and many of us know of them.

But for more than 20 years the provincial government of Ontario of the time has thought of it as a plan for that population that was at that time housed within facilities, away from their families, away from the community, and cared for. There were papers written about

this, many projects, many reports, and it was felt that a cohesive community base system could be developed for the developmentally handicapped, so that they could take their rightful place within the community.

I will not go through the history for you. You all know the history, it is there. There was a move from Health to Community and Social Services because there was a feeling that we wanted to remove the health focus, we wanted to emphasize the opportunity, or they wanted to emphasize the opportunity, for the developmentally handicapped to have a full place within the community.

The five-year plan between 1982 and 1987 saw residential programs lessen. People placed in residential situations lessened in that 1,755 moved out of their residential facilities and into the community. More moved into day programs, and that taught the government that in fact it could provide community opportunities for the developmentally handicapped to live in the community and to work in the community.

It also taught them that it would take time, because there was a great deal to do. They had to accustom the community to the whole notion of once again assuming responsibility for all its citizens, the developmentally handicapped among them. They had to ensure that labour was willing to see it as possible for the developmentally handicapped to work there. They had to be certain that there was an opportunity for these people to take their rightful place and that there were services in place to accommodate their living within the community. The attitudinal changes, the changes that had to be made in the services in the community, the changes that had to be made in the attitudes of those potential employers, all of that would take time.

Now we are four years into the multi-year plan that was outlined in Challenges and Opportunities, and it was my decision that it is time for a review of the process, a review that would focus on what is best for the client.

There are questions that must be asked about the process such as: Is the process one that will ensure a good, understandable, clear communication about who carries the responsibilities for the developmentally handicapped when they are moved from a government facility, facility 1, schedule 1, into the community?

Is the process one in which criteria and standards of expectations are shared with the new community facility so that there is no misunderstanding about what those expectations are? In fact, have those expectations been designed? Have those criteria been written? Are they commonly shared with the community facilities and are they used as a basis for monitoring the care of the developmentally handicapped?

Is the process one that can be monitored internally by those service providers and externally by the ministry, which is ultimately responsible for the developmentally handicapped? Is the process one that shares the responsibility almost to the point of being advocates on behalf of clients and in the clients' best interest? Is it one that includes alternatives? Does it include redress when the client cannot remain in the original circumstance?

These are important issues. Not all clients who are brought out into the community facility have the kind of experience which allows them to remain there. There are situations where this must be ended.

Is the process one that provides adequately for all clients, even where services are sparse? Is the process one that promotes the client to develop to the best of his or her abilities, or is the existence of a workshop facility, which is an improvement over some situations where they have nothing, but does the need for a critical mass for such a workshop facility operate in a way that it prevents clients from developing to the best of their individual abilities? Does the program allow the client to develop to his full capacity and to his full work level beyond the sheltered workshop?

Ultimately and most emphatically, certainly by far the most important question becomes, is the client at risk? If he or she is at risk, when does that occur? What situations cause that client to be at risk? When is it most frequent or most common? Or if not at risk, when is the client in a situation where the best is not being done for him or her because of frequent changes in stats? What contributes to those frequent changes?

1520

When we looked at that, we realized there were other issues we had to consider. In order to consider them, there were groups that had a great deal more experience than we did with this particular question. Also, there were groups who were directly involved, and those groups are the clients. People First is one group that has among its members a representative of the client group. Those groups were associations such as the Ontario Association for Community Living; the union group that represented the front-line workers who had something specific to say; parents of those who had moved into community facilities, parents who were fearful of their family member moving into a community facility, or who had had the experience and had left the community facility.

So there were many groups we had to discuss it with and there were many things that we had to talk about. Not least among those things was a continuum of service, a continuum which allowed not only the change from a schedule I facility to a community facility but also allowed for a stable working group that worked with the client so that the client was not put at risk.

When that was done and when we had finished the review, though we took off the temporary hold we did decide that the review would continue. We have taken some steps in order to carry on this review. We are sponsoring a forum of consumers, families, advocates, workers and leading experts in the field of services to people with developmental handicaps to provide leadership in the areas of program development and delivery. Some of those people we have already been in contact with and others we will be continuing to contact. A project co-ordinator has been named in order to do this.

We identify existing community services options and recommend ways to improve their responsiveness to individual needs. This includes many different processes. There is a peer review process that is being developed in

schedule II facilities. A committee of agency and ministry staff is reviewing existing processes focusing on quality of care. We are identifying gaps, we are identifying weaknesses, we are developing short- and long-term plans of action.

We are also making sure that our communication to families, to community agencies and other interested parties, that the principles and the guidelines used in the placements of all individuals and facilities is the same. Things were happening differently from different facilities and around different clients, which made for some confusion, some lack of consistency and some gaps, and the possibility of differences in systems which would put clients at risk. We have asked for standards and criteria that are definite and that are shared and communicated.

We are working to reduce the significant gap in wages paid to workers in ministry facilities compared to the wages paid to workers in community agencies. This is important, because the difference creates a kind of discrepancy which allows for many, many changes in staff. Several of the community facility operators have said to us, "The more the staff is changed, the more likely things are to happen." We are certainly considering this as being an important focus, that we find ways of maintaining a regular staff with the facility.

In addition to that, we supported the announcement made by the Minister of Citizenship around advocacy, but we also want to ensure that within the facilities there is a feeling of responsibility, a monitoring system which makes it unnecessary for every situation to wait until an advocate has assumed responsibility for it, before that situation is improved.

I could emphasize for you further the government's commitment to the fact that we are committed to the multi-year plan, and we do believe that the developmentally handicapped should be in the community. I feel that is unnecessary. What I have to emphasize to you is that I feel it is my responsibility that the process by which these people are moved into the community, the procedures used while they are in the community facilities, the accountability not only of the community facilities but also of the ministry must ensure that the developmentally handicapped are not at risk.

I would be willing at this time to answer any questions.

Mrs McLeod: Your opening comments, as well as the ongoing concern about the issues, give rise to a number of questions. Because I know we are limited in time, I will focus mine on one question and one supplementary and trust that the other issues will be raised in other order.

As you speak about the necessity of having careful plans and taking time to ensure that the movement of developmentally handicapped people in the communities is carried out well without placing clients at risk, we have to acknowledge the fact that there was a plan in place and it was a plan intended to take the time needed to ensure that the processes were carried out very carefully. In fact, people who were members of your party at the time the plans were introduced were concerned about taking too much time, that the government of the day was having too careful a process and that we were not moving fast enough

to move people out of institutional settings and into the community.

The questions you are raising today I would believe are all issues that were acknowledged when that process was being developed. It was one of the reasons why it was as careful as it was. Yet you seem to have implied by raising those questions again in your review that there were not clear expectations, that there were not criteria in place; if there were, that those were not clearly understood by the community agencies that were obviously absolutely important in the delivery of the standards of program. In fact, you have suggested that maybe standards did not exist. I have some difficulty with that implication or even a suggestion that the ministry would have proceeded with a program if it felt clients could be at risk in any way. I would like that to lead into, then, a question and a supplementary.

First, were you in fact hearing from the community agencies that there were not clear expectations, that they did not understand the criteria that were being used, that they were concerned about clients being at risk as this multi-year plan was proceeded with?

Hon Mrs Akande: First, I have to say that the retrospective scope is very exact. Though I am sure there were plans put in place at some point down the line, I was evaluating their use at the time of my putting this on hold. Was I hearing this from the community agencies? Only after the questions were asked. I was hearing it from family members, from people who were unclear or unaware of there being specific standards in place, who did not know what those criteria were or knew of oral exchanges which had referred to standards and criteria but had not seen them. I, too, asked for those standards and criteria as a uniform thing and was not able to receive them.

1530

Mrs McLeod: I appreciate that, although it is still difficult for us to know specifically who was raising the concerns and what their concerns addressed. Again, I take as an assumption that in carrying out a plan as comprehensive as this, the ministry would be maintaining close contact with people who were involved in delivering the plans and also the clients themselves, and were monitoring the program.

To be more specific, can I ask you whether, in raising the basic issue of your sense that there might have been clients at risk, there were specific situations you became aware of where, in the course of carrying out the plans for deinstitutionalization, clients were placed at risk?

Hon Mrs Akande: I was made aware of situations from families of clients—I have had two situations in particular—who had been in community facilities and were no longer, and by clients whose families were fearful of them being moved to community facilities because of their inability, their not being given any particular process and sense.

Mrs McLeod: If I can just be clear then, it was not concerns about those who have already been moved out of institutions.

Hon Mrs Akande: I did say that some had been moved to the community facilities and had subsequently been moved out of those facilities.

The Vice-Chair: I need to remind members that I will be dividing the time equally among the three parties initially, and then follow a waiting list. Those whose names are coming up are Mr Owens and Mr Martin. I turn my attention to Mr Jackson and then Mr Owens.

Mr Jackson: I would like to thank the minister for coming today. My questions have to do with the fact that there have been what appear to be several policy changes with the multi-year plan in the last five months with the change in government. One area that is of concern to me is that the waiting list for community-based residential care is, as we know, at a crisis level. When the multi-year plan was originally envisioned, it was the plan—it stated right in it—that there would be matching institutional placement from those leaving institutions, as well as placement from within the community where there was no prior institutionalization. This was the practice and the procedure and was going along extremely well. Yet we are noticing that now the government is approaching community agencies simply to plan for the transfer of institutional people with no matching community funding. This was the case at least for two or three of the local associations in my own region.

My question first has to do with whether there has been a formal change in your government's policy of matching institutional and community transfers, as the practice indicates. Will this policy be changed formally, or what advice can you give the committee in terms of the observation of that event and what it means to government policy as it relates to these lists?

Hon Mrs Akande: I must say first that the waiting lists relative to those who are transferred directly from the community is something we inherited. Those waiting lists were waiting for me, so to speak, as I arrived in office, so this is not a new situation.

The other thing is that we are attempting in every way possible to move those from the community as well as those within the facility, but the funding was so structured previously to address in a priority way those who were moving from the facility into the community facility, moving from schedule I or schedule II into the community facility.

Mr Jackson: Can your ministry staff provide us with specific statistics? If I understand you correctly, you have not said whether you are seeing an overemphasis, if not an exclusive emphasis, on institutional transfer versus community based. Are you aware of that or can you share with us the transfer numbers, whether it is by month, for the track of the last year, so we can see if a trend actually exists? We are hearing this. We will ask questions about it. I am merely trying to establish whether the minister is aware of it and/or whether it is a policy issue.

Hon Mrs Akande: It is not a policy we have devised or designed. I do have staff here who can give you numbers, and that would give you a basis for making that comparison. Also, it is a fact that when I arrived at the

ministry there was a waiting list and I have to move that along as quickly as possible. The difference between from the community and from the facilities is something that the staff will be glad to provide.

Mr Jackson: If they could share that.

I want to quickly ask you about the enhanced supported independent living program which has not really gotten off the ground. It was envisaged and developed four years ago. I wonder if you could share with this committee when your plans are to implement that, if you have any immediate plans to implement it or if it is one of the things that is being held up in review as part of the review.

The other one—and I will just share it so I do not have to be cut off by the Chairman—is to do with the sheltered workshops and the wage policy that was under review. It was dropped at the 11th hour, I understand. I know People First will talk to us about that indirectly, but I thought while the minister was here, if you could share with this committee whether you have made any decisions or any information about your government's position with respect to the wage and legislation developments that were being actively discussed prior to the change of government. Those are my two questions and a policy one.

Hon Mrs Akande: Let me start with the first one, the independent living. We are, as you know, very involved at this point with other initiatives which include this particular population. As you look at long-term care and certain aspects of the way that might be provided, you can see opportunities for the inclusion of this population relative to long-term care. So that is coming down very quickly. What we are trying to do is make as all-inclusive a plan as possible. That is number one.

The second one concerning sheltered workshops and wage legislation: it is something we are looking at and it will be addressed. I suppose you know the issues around that, that some of those included in sheltered workshops are there more for their therapy than their production, whereas those others who are there for their production certainly should come under some kind of wage policy. Then there is a third group and that is a group that maybe should not be at sheltered workshops at all, who can be trained with on-the-job counsellors to assume a place in the regular labour market.

Mr Owens: I would like first to thank you for your report. My question is with respect to advocates and advocacy. The late Father Sean O'Sullivan released his report, *You've Got a Friend*, a review of advocacy in Ontario, and I am wondering if you could tell the committee where the ministry is in the implementation of the O'Sullivan recommendations.

1540

Hon Mrs Akande: Actually, as you know, this government has taken a whole new stand on advocacy. The Minister of Citizenship made an announcement in terms of advocacy and we are looking to Mr Lightman's report to implement certain aspects of those recommendations because they will be influenced by it.

Our feeling in this ministry is two things. One is that there has to be an internal—and I have been cautioned

about using advocacy—monitoring system that in fact should address and should be the responsibility of all those who are working with people at risk to respond to their needs, to report anything untoward, to advocate on their behalf. Then the outside group, the advocacy that is going to address or be responded to or reporting to the Minister of Citizenship, should in fact take an overview and a distant view and deal with those situations of the report that are beyond that level or that have escaped the view of that or have at least put people at risk.

The Vice-Chair: I am afraid, members of the committee, we have run out of time and I would like to take this opportunity to thank the minister for making her appearance before the committee. You are always welcome.

Members of the committee, as I pointed out earlier, we will try to be as fair as possible in the distribution of time and I will keep to the rotation as we had in the previous set of hearings, one question from each of the caucuses and then we will follow an order of precedence thereafter.

PETER CLUTTERBUCK

The Vice-Chair: We will now be hearing from Peter Clutterbuck, independent human resources consultant. I would ask that he take a seat please. As I will attempt to remind each of the witnesses, you have half an hour for your presentation, which you will divide as you see fit. If you would like to allow for questions for part of that time, that is entirely up to you. Welcome to the committee.

Mr Clutterbuck: I think you have this statement that I prepared. Actually, I would like to walk through only the first four pages and refer as I do so to the attachments that are in it and elaborate extemporaneously as I proceed through the short four-page statement.

I am pleased to have this opportunity before the legislative standing committee on social development to present some thoughts and views related to the ministry's service mandate for individuals with developmental handicaps, as defined in *Challenges and Opportunities*.

I guess I was asked as an independent policy consultant and I do not know how my name surfaced and your clerk maintained the confidence around how that occurred. That is fine with me, but since I was asked as an independent person and since I am involved in some things in the community that have to do with supports to people with developmental handicaps and physical handicaps, I did consult with the people with whom I am involved in these initiatives and bring forward really a perspective which they represent, along with me I think, or try to promote in the community, that I think will be a little bit different from perhaps what much of the weight of the discussion which you have here in other presentations might bring forward.

Returning to my text, I prefer to offer a very particular perspective which I, and others with whom I am associated, feel strongly needs to be heard more often in public policy forums. This perspective is rooted in the experience of everyday community life and the fervently held belief that all meaningful community living must depend on personal commitment to each other and freely given relationships within communities.

This perspective distinguishes itself certainly from institutional life as commonly known by developmentally handicapped people and their families, but also from community-based service systems as a promise which strictly on its own will also fall short of real community living.

I refer you, perhaps for later reference, to the article I have attached by John McKnight, called *Regenerating Community*, which was actually, although published in the *American Social Policy Journal*, delivered as a paper at a 1985 national conference on mental health in Ottawa, and really, to try to be a bit more explicit, I also attached a statement by Judith Snow, a one-page statement on the community experience.

Judith Snow is a person who is quadriplegic but has worked extensively in the field, as well as living a life which has taught her a lot about rejection and acceptance in community and the importance of personal relationships. She works with developmentally handicapped people in training and integrated education in particular. A version of this statement was published in a recent issue of *Perception*, the Canadian Council on Social Development magazine.

Just to be a bit more explicit at the outset of this distinction that I am trying to establish between a community perspective and community-based service systems, we really, when we refer to this community perspective, are talking about life experience of a developmentally handicapped person, which is integrated not by means strictly of services and formal arrangements in which paid workers are involved in people's lives, but which is centred around a real experience of family where possible, or community relationships that are sincere, freely given, that might be part of any type of neighbourhood association, church or identifiable community group and which really try to avoid what is often as unfortunate an experience, or can be, in terms of the range of relationships which a person has, as institutional life might be.

I think we all recognize how segregating and isolating institutional life might be and we are trying, as much as possible, to bring people home to our communities, but there is of course, and I know this from my own professional experience in the field—there is a biographical note attached which gives you some idea of my previous involvement professionally in this field as well as my current—but also from my own involvement as a personal advocate with people who have developmental handicaps and sometimes physical handicaps, that people can live within a community and still be segregated.

They can be part of a group home in which they do not really choose whom they might live with, and they might, through the course of a day, only see and relate to other people with labels similar to themselves, which they might be very happy to be in community with but which they have not really chosen to live with. They might, during the course of that day and that week, perhaps primarily relate to, besides the other people with whom they live or work in the sheltered workshop, only other paid staff. They might go from group home to sheltered workshop to organized programs in the community which, again, are primarily segregating, although I know that the associa-

tions for community living and other service providers are as much as possible trying to break this pattern and achieve more integrated experiences for people.

But this, too, can be as isolating and segregating for people with developmental handicaps as institutional life. This is the unfortunate circumstance which happens when a person's community experience is really defined more by community services than it is by real community relationships with other people who are not paid to be with them. As you will see in the rest of my presentation, I do acknowledge a very important critical role for the community service system, but it should not be central in a person's life. We are essentially talking about the difference between not so much segregation and integration, but rejection and acceptance, acceptance being that the community openly and welcomingly makes itself inclusive and available to everyone.

We turn to the second paragraph. At the same time as I put forward this particular community perspective, we who hold it recognize that the realization of its ultimate vision will mean arriving at some reasonable accommodation with the world of community service. The preferred accommodation in that respect and one for which many of us are working is transformation of the community human service industry, so that the human, financial and other organizational resources invested in it will become directed towards supporting a vision of a caring community which minimizes service dependency and maximizes building personal relationships and community connections.

A systemic transformation of the order suggested above, even such a transformation within existing traditional community service organizations, will be challenged as idealistic and as vainly in search of some unachievable, even mythical, vision of community life, yet the multi-year plan and the five-year plan before it, whether economically motivated or not, have demanded their own kinds of systemic and organizational transformations and reallocation of resources from an institutional to a community base. Deinstitutionalization, even at the modest scale proposed in those plans, would have been discounted in Ontario as pipedreams just 20 or 25 years ago. Therefore, as long as we are talking about significant change at some level when addressing the multi-year plan, let us consider some possibilities which reach further than might originally have been imagined and which even today can be seen emerging from some of our communities.

At this point, it is appropriate to comment directly on the multi-year plan and its articulation of the ministry's service mandate. From my point of view and the people I have talked to, the weakest part of the mandate in the strategic objectives stated in *Challenges and Opportunities* is the clarity of the commitment to deinstitutionalization. We recognize that *Challenges and Opportunities* was put out by the previous government and perhaps is being reviewed and modified by the current government. Within that document, a phase-down of large institutions is not as clear a statement to end institutional living, although elsewhere in the paper the planned phase-out of institutional care for developmentally handicapped people is indicated,

although as an unspecified long-term objective. One might also question, given the paper was put out in 1987, the adequacy of a seven-year target of a total of 2,000 people in institutions and nursing homes for return to community when at that time, in 1988 at least, over 8,000 people were residing in schedule 1 and 2 facilities and nursing homes.

1550

The announcement of a temporary hold on deinstitutionalization in the fall of 1990 raised some question in some quarters about the new government's commitment even to the minimal objectives of the multi-year plan. The minister is to be commended for the quick review that was conducted leading to the removal of the hold in late December, and the renewal of her ministry's commitment to improved community living opportunities and to the return to community of people in provincially operated facilities.

The minister also indicated in her statement of 20 December several initiatives, and she repeated them here today, that will place the government in position to establish its own mark on deinstitutionalization and community living for developmentally handicapped people, and we await those anxiously. There are, however, two clear commitments which would be good to state explicitly, as I think were put forward to previous governments in 1982 and 1987 by the Ontario Association for Community Living. The first is an immediate zero-admissions policy to provincially operated or funded schedule 1 and 2 facilities and nursing homes, and second, a clear commitment to complete phase-out of institutional living by the end of this decade.

Probably others will recommend and bring forward similar types of comments and recommendations and might be willing to spend or interested in spending a lot more time on that. My primary interest is moving forward the legislative committee to this community perspective and what it would mean in terms of an innovative model or approach to service for people or support and community for people with a developmental handicap.

All who share the community perspective which I offer would agree that the multi-year plan does identify three critical areas of support for community living: family, community and work. To my mind, the proposed strategic objective of community support for 8,000 to 9,000 developmentally handicapped people by 1994 is also admirable as a public policy commitment. But my concern and the concern of others is that the mandate for these areas is presented so strongly in service development rather than community development terms. The distinction is real, not semantic.

The examples of specific initiatives appended to this statement are concrete expressions of community living alternatives that are grounded in nurturing and sustaining committed, stable, reliable and freely given personal relationships in the lives of people with disabilities. These examples do not deny a role for organized formal community service support to individuals who have complex needs. The function of paid service in this context is to support a very individualized expression of community experience for

people with disabilities. But community through family, friends and natural community connections should be the life-defining experience for people with developmental handicaps, not service. Service should support and supplement, not supplant, the community life experience.

Just quickly to refer to those examples that are appended to the statement, I am talking first of all to the housing co-operative, which includes a component for support called NABORS, or neighbours, allied for better opportunities in residential supports. I am a volunteer board member of the NABORS component of CHORD and participate in CHORD co-operative housing meetings. We have in our membership eight families who have physically, developmentally or multiply handicapped individuals and four other individuals who are physically disabled as part of our membership, and a larger membership of family, friends, advocates and other interested citizens around whom housing is a primary concern, who have joined together to create a co-operative housing effort that will eventually house about 250 people, of whom 12 will be people with developmental disabilities or handicaps, physical disabilities or are multiply handicapped.

Our intention in coming together—and we have our housing financing and we will have our co-operative housing built in the city of York in late 1992—is to create the type of community together where the disabled people, some of whom are now in institutions, will have the opportunity to form relationships within that co-operative and within that larger community so that they will be active co-operative members and participants and not just people who have a place to live and service that allows them to live there.

NABORS itself, if you read through the appended document, will be an agency, a community-run board made up of the co-operative membership, that will employ staff in terms of a co-ordinator and development worker, and will hire attending care workers and other guides and supports to developmentally handicapped people. So it will very much respond to the particular special needs of the individuals who live with us in our co-operative.

One of the first stated missions and purposes of NABORS is to help the people who have not friends, who have not community connections, to establish relationships with other members of the co-operative. In fact, when we invite people to join us as a co-operative, we intend to make it very clear that we are opening up ourselves to a community that is quite willing to participate and interested in participating with people who are disabled and perhaps have not had the opportunity to form the same types of friendships as others in the past. There is a similar model attached called the Winnipeg Prairie Housing Co-operative, upon which we at CHORD and NABORS partly modeled ourselves.

You will also find appended to the statement an article called *An Invitation to Supper*, which talks about two young men who went to have supper in a neighbourhood in west Toronto, the local parish. As a result of those types of initiatives in which a support worker helped them get to know other people in the parish—the

two young men had special needs—and as a result of the continuing involvement with that parish, St John's Anglican parish in west Toronto, there has come out of that group something called the St John's trust, which is committed to supporting in community those two individuals and individuals from three other families who have special needs and multiple handicaps.

The St John's parish has set up a trust and has developed a proposal, which it has submitted to the Ministry of Community and Social Services, that is intended to provide the types of particular service supports required so that the individuals and families who are involved can remain active in parish life, stay with their families and establish, when they get old enough, their own independent living opportunities in that community.

The St John's trust and the service proposal that has gone forward to the Ministry of Community and Social Services is another example of how people are not integrated into community, but paid supports are integrated into the normal patterns of the lives of families and individuals who wish to live in community, no matter what level of disability they might have.

I might also mention at this time that CHORD and NABORS also have a submission in to the Ministry of Community and Social Services for the funding of our service component.

The multi-year plan does not rule out these types of innovations in community living, but its central concept and language are drawn from the domain of community services and formal human service systems. The plan does not explicitly recognize nor indicate provision for the community development work that must be done with families and communities for the kinds of initiatives described in the attached material.

Community living strategies that integrate community development with service development for the benefit of developmentally handicapped persons would include the following four main components.

First: individualized and flexible funding that recognizes both the community development work and the service development costs in helping an individual become established in community, not just funding; in other words, programs and services for people, but the developmental work that must happen to help people make connections in community life.

The second major component: brokerage assistance for individuals that attends to the building of personal relationships and informal networks of support as well as securing the appropriate paid service supports; in other words, not brokerage assistance that just takes assessments, develops plans and refers people to services or just arranges formal services for people, but brokerage assistance that is attentive to helping people establish personal support networks within the community in which they will be living or have chosen to live.

The third component: recognition and legitimization of external personal advocacy for developmentally handicapped individuals. The ministry's participation in the recently announced advocacy commission holds some promise in this respect.

The fourth component: integration of these brokerage models into generic community groups; in other words, the opportunity to establish a brokerage model, the opportunity to be this way in which people bridge themselves into community in terms of personal relationships as well as formal service supports, should not be strictly the preserve of community service agencies that are mandated specifically for that purpose, but should more often be linked to other types of community initiatives like housing co-operatives or like parishes such as St John's Anglican in west Toronto. In other words, we can introduce brokerage models into the generic community institutions that we have and should not have to depend only on those community service agencies that are in place.

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I am under no illusions that this approach to community living will win the enthusiastic support of established interests in the field, whether institutional community-based service agencies, professional or organized labour. There are real interests in these sectors which do require some accommodation in a large-scale move to reorient resources in the way proposed. There are community service providers who have already struggled with this challenge and have tried to adapt accordingly and who are trying to help parents and consumer groups within their own organizations develop their own models, control them and have an affiliation with the community service that allows the community effort to still be owned by the people who will be most directly involved. Some community service providers are engaged in that type of activity and support it.

In the ministry's own regional and area offices there are funding officers and program supervisors who are excited about some of the innovations emerging from parent, advocacy and community groups and who are trying to stretch the mandate and provisions of funding programs available to them in order to give these initiatives a chance. So there are people within the system who recognize the potential here and who recognize it has its place in the overall system. Although hardly a wave of change at this time, these signs of openness and movement within the system are hopeful.

Those of us who hold this vision of community living do not expect large-scale transformation of the human service world in the near term, but we do believe our approach merits some place in the community living strategies promoted through the Ministry of Community and Social Services and that is why we hope and look forward to funding of the types of initiatives which I put forward earlier to you. The minister's call for a new beginning and a fresh start in her announcement on 20 December opens up the space needed for innovative initiatives. I encourage this standing committee to urge the minister to establish a funding stream for community living innovations. When I say "I," I have talked about this with other people involved in personal support network-building and they share this interest. Establish a funding stream for community living innovations based on the four components identified above as part of the ministry's renewed

commitment to deinstitutionalization and community living for developmentally handicapped people in Ontario,

I would be happy to try to answer any questions you might have on this which I have brought to you.

The Vice-Chair: Thank you. We have approximately 10 minutes for questions. I have Mr Beer and then Mr Jackson.

Mr Beer: Thank you for your submission. I think the distinction that you make around the question of community development and preparing communities to really accept and to welcome those who are developmentally handicapped into the community, those four points you have set out are interesting ones to look at in terms of how a program might develop to support that.

One of the issues that seems to come up when we talk about this particular area, particularly among some parents whose children, or now younger adults, are in institutions, is precisely what, when they move to the community, is going to be there. As parents grow older and much older, just the concern about, "Where is my 45-year-old or even 50-year-old son or daughter going?"

Mr Malkowski: On a point of order, Mr Chairman: Would you mind beginning over again, please? I missed all of that.

The Vice-Chair: Would you like to repeat that, Mr Beer?

Mr Beer: I will try. First of all, I wanted to thank you for your presentation and I think the four points that you raise around the issue of how we work with communities so that they become welcoming and accepting of those with differences is very important. The services are important too, but that kind of development is very important and you have given us some examples that will be interesting to look at.

My specific point was around, in talking with parents of developmentally handicapped individuals, many of whom now are perhaps living in our communities or are going to be living in our communities, and the "children" are in their 40s, perhaps even their 50s, and the real concern of parents about what kind of community they are going to live in, and from that, a searching for different kinds of models. I would be interested from your experience and the comments you have made about NABORS and the West Toronto group, how you see organizations like Jean Vanier's L'Arche and the Camphill program that has come from Scotland, in terms of different sorts of models that perhaps we need to look at that are going to encompass maybe a greater variety of needs and a greater number of approaches than simply between, "You are in an institution that has 1,000 or 1,200 individuals," and "Now you are on your own, living in an apartment." It seems to me there is a tremendous amount of tension and even fear at times in seeing how we make that transition to community life.

Mr Clutterbuck: I think those models you mentioned are in some ways pioneering the whole spirit of community that I was referring to, although the more typical choices for people in our society tend to be in less large types of settings, even if communities in terms

of congregative living. When people do choose to live in those arrangements, typically more often they choose things like apartment buildings or co-operatives or the kinds of things that I mentioned.

In fact one of our people, who I know from west Toronto, who is referred to in the article, is currently in Camphill. In terms of when the whole arrangement gets set up, he will eventually move back into his neighbourhood, his home community. I think the challenge for community service workers and for organizations is clearly to make more available to people those types of choices that are built around something like the spiritual dimension of the L'Arche movement, for example. But other people should have the choice for more normal neighbourhood and community life as well, and that is not too often made available to people.

I think community service workers, when they start to work with individuals, need to look at opportunities in which people themselves, family members for example, can come together and start to formulate their own ideas and visions about what they want. In each of the two cases I mentioned it started with a group of families who had opportunities and were supported by paid people who might be characterized as community development workers, to do a little bit of visioning about what they would like for their children, and where their children could participate, they participated as well.

So the sensitivity to not strictly thinking about case management or procedures which deal strictly with people on an individual level, and the objective is to find a placement in the community, but more the community development orientation about looking at opportunities for people to come together and the skilled worker who we should be providing to the system, and who we are providing, in many ways, can help those people realize their potential of coming together to organize something for themselves and, wherever possible, to get the support of existing agencies like the associations for community living and other community service providers who really do have the workers to do this type of thing, actually. This is happening in some agencies actually in Toronto.

Mr Jackson: Peter, can you tell me if you are familiar with the former government initiative for one-window access for long-term care and the disabled component of that? Are you just basically familiar?

Mr Clutterbuck: I am familiar, more in particular with the disabled component of that, but also how it has evolved since.

Mr Jackson: Good. You are familiar then with the 14 projects and you are familiar with the 14 officers who have been put in place and that they are building linkages in the community to establish frameworks and so on. My initial examination of that, and I have been keeping abreast of it, is that it appears the disabled community is at the end of that analysis and integration. I have not heard yet from the government at any point about putting in context community living and the one-window access, because these are substantive issues here—funding, program enhancement and so on—for

those members of the disabled community who are, shall we say for want of another word, older.

I am not seeing it anywhere. You are the second person present, so that does not mean that it is not going to surface, but I am going to be looking for it. I wondered if you had some specific comments. I understand what you are driving at. I see the one-window access as it relates to this community as being rather helpful if it follows the model. You do address some of those points. Can you expand on that very briefly, because it is going to have a major impact on the disabled community in terms of having the one-window co-operative model for funding purposes in terms of the criteria that you set out.

Mr Clutterbuck: You mean what kind of implications that approach might have for neighbourhood-based organizations like NABORS to be able to try?

Mr Jackson: Precisely, and I am concerned that we are not hearing from the other ministries. We could isolate the multi-year plan from that other policy trend which we are seeing unveil itself in this province. I am looking for it to integrate itself and I am not seeing it. I see us moving in two directions.

Mr Clutterbuck: To keep my comments strictly related to the opportunities for developmentally disabled people, as I understand it, the previous government had indicated its interest in piloting some different approaches around physically disabled people. If you look at the types of elements they have built in and look at one-stop access, you will recognize some of the components among the four that I identified. I think probably, at least in one-stop access, it was not as clear, the importance of personal support networks and personal advocacy. I think that what we really are interested in and why we are promoting, again from this personal-support network base of people that I am involved with, community living innovation is to really test out some of these approaches which view the kind of things I just explained to Mr Beer with respect to people with developmental disabilities no matter what their age, young, old. In our situation the oldest person at NABORS who requires some support will be in the 50s, I guess.

So, we see the expectability of the same types of principles, and we look for opportunities to demonstrate, and that is why we ask for community-innovation type of support.

The Vice-Chair: Mr Clutterbuck, our time has expired. Thank you for making your presentation.

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ADVISORY COUNCIL ON SPECIAL EDUCATION AND LEARNING DISABILITIES ASSOCIATION OF ONTARIO

The Vice-Chair: We will now be proceeding to the Advisory Council on Special Education and Learning Disabilities Association of Ontario, Eva Nichols, who is the chair, Margaret Walker and Margaret Pollard. Come forward please. Welcome to the committee. I would like to also remind you that we have half an hour and we are on a very tight schedule. If you would like to leave some time at the end of your presentation for questions, it is entirely

up to you. Please proceed, and if you do not mind introducing the other persons who are with you, we would appreciate that.

Ms Nichols: Thank you for giving us the opportunity of speaking to this committee. My name is Eva Nichols and I chair the Ministry of Education Advisory Council on Special Education. I am also executive director of the Learning Disabilities Association of Ontario. Margaret Pollard is a member of the advisory council and an education officer with the Ontario Association for Community Living. Margaret Walker is also a member of our council and she is past president of the Association for Bright Children. The three of us are representing the advisory council.

Our comments are going to be fairly brief because I think it is important that there be dialogue, and you will note that what you have in front of you on the pink sheets are point-form notes. I had not planned on submitting anything in writing, but this morning was asked to, so that is why it is not a full-fledged brief. It took me about half an hour at the computer this morning.

We are particularly glad that we have this opportunity of speaking with you, because the Advisory Council on Special Education, of course, has a primary mandate to deal with education. We primarily advise the Minister of Education and the ministry on matters that pertain to special education issues for exceptional students in Ontario. Nevertheless, we do have obviously an interest in what happens to these students before they come to school, in other service areas when they are at school and what happens to them afterwards. We occasionally get the opportunity of commenting to other ministries and to other services about some of these issues. We are 17 individuals who represent quite a variety of groups and we believe that we probably cover all the significant stakeholders in special education.

Over the last few years we have particularly reviewed and focused upon the status of individuals who are identified as developmentally disabled and the services that are available to this population in Ontario. We have not reviewed the Ministry of Community and Social Services multi-year plan, so clearly my comments are not going to focus on that, but Ms Pollard is certainly able to answer any questions that you may have specifically relating to that plan.

As a council we promote enablement, empowerment, access to a full range of appropriate services, based on the needs of the individual, and support to assist individuals to develop their full potential, whatever that potential may be. While these may sound very highfalutin words, we really do commit ourselves fully to that and we believe that it is possible to deliver such things. We support the delivery of these services in the most enabling environment, and we firmly differentiate between most enabling and least restrictive environments because we believe that the welfare of children demands enablement.

This enabling environment, of course, has to begin with the family, and therefore we fully support the trend towards the retention of children who are identified as

developmentally disabled within their family. It is, however, very important that the requisite support system for that family, including such programs as respite care, the special services in the home, assistive devices and numerous other services be made available.

One of the concerns that we have had in the past is that there has not been adequate interministerial co-operation and collaboration in the development and delivery of such services. If probably there is one thing that the subsequent ministers of Education were fed up hearing from us, it was, "Would you please, ministers, get your act together and start working together for the benefit of children."

Somewhat tongue in cheek, we have also on occasion commented on the fact that for exceptional pupils there should be a Ministry of the Child so that indeed families did not have to worry about whether they are dealing with the Ministry of Health or Community and Social Services or Education or Skills Development or Labour, but just a ministry, a government service that focuses on the needs of the individual.

We very firmly believe, as a council, that people with developmental disabilities have the right to have available to them services that are within and not outside the regular educational, social service, health and other support systems. I should elaborate that we do not mean, therefore, that the only service-delivery model that should exist is one that is fully mainstreamed—and I know mainstreaming is an educational concept, but I think you all know what I mean. We believe very strongly that they should be integrated to the full extent that meets their specific needs at a given time, and both within any integrated setting and also in any special service area there needs to be appropriate support, which includes trained professionals, accommodation of special needs and full evaluation and monitoring of those services for the best interests of the individual.

In order to assist the families of these individuals, we believe firmly that there must continue to be community-based special services, as the individuals and families need them. In order to guarantee the continued existence of such services, there must be a greater emphasis on both corporate and local planning, with the local interpretation of the corporate direction being more even across the province. In other words, services should not vary significantly from one jurisdiction to another and should not reflect either individual municipalities' philosophies or commitment to individuals with special needs.

Moving now to the educational system, and we recognize that is not your primary mandate but it is a great concern to us that the legislation still exists retaining the term "trainable retarded." I think there is completely universal agreement that it should be eliminated. The fact is that those of you who were a part of the select committee on education will have heard us as a council and many others say that it is now five years since that legislation has been pending and it still has not been introduced. We really wish that somebody would do something, and if you can be the group that facilitates that, we would be very happy about that.

We believe that pupils with developmental disabilities should be a regular part of the special education delivery system within a school board. They should not be separated in any way from their peers and they should be served and educated in the manner which meets their needs best.

As a council, we have particular concern about people with severe disabilities once they turn 21. We have, in fact, taken the unprecedented step of submitting a paper on this document to the previous Minister of Community and Social Services, and our hope is that at least in this area the two ministries will work well together. The goal, of course, is to ensure that people with developmental disabilities are self-supporting to the greatest extent possible, with supplemental funding available to promote independent living. Current programs focusing on employability and job readiness are very patchy in terms of availability and access. There should be greater linkages in terms of vocational counselling, training and employer sensitization.

We feel very strongly that services that exist should be based on severity of need rather than the diagnosis of a given disabling condition. We know that your mandate is with the population that has developmental disabilities, but we want to mention to you that we are concerned that there are other people with disabilities, severe disabilities, whose functioning whose functioning may be as much affected as that of people with developmental disabilities, who are not able to access current services because of some policy requirement at a particular ministry.

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Our council supports the phasing down of all large institutions. We would hope, though, that this process would include full community consultation and corporate planning for the use of these facilities and for the community-based support services for the individuals who are being deinstitutionalized.

We would like to recommend for you to consider that future directions must include: implementation of all outstanding legislation; improved training of professionals including teachers, but also others who work with people with developmental disabilities; improved access to post-secondary training and education including to such services as apprenticeship; greater interministerial co-operation and collaboration; programming based on severity of special needs, not diagnosis; focus on enablement, access and equity; and ultimately, recognition that individual needs will vary and that programming must be predicated on these needs and not on abstract philosophy.

Mr Chairman, I would like to stop speaking at this point and turn this over to you and your members for any questions.

Mr Malkowski: I would like to thank you for your presentation. You are representatives on the Advisory Council for Special Education. Do you have any consumer representatives on that advisory council?

Ms Nichols: At present we do not. The Ontario Advisory Council for Disabled Persons has a seat on that council which has for the last year been empty, for a variety of reasons which do not relate to the special

education advisory council but rather to the Ontario advisory council. I also know that the four parent associations that are represented on the council frequently consult with their consumers. Furthermore, we are in the process of a sunset review and this week we are having our very last meeting as the current council. It has been recommended to the current Minister of Education that as a new council is reconvened later on this year, there should be some consumers, in particular representatives of the deaf community, appointed to council.

Mr Jackson: I am fascinated by why "tongue in cheek, the Ministry of the Child." We talked about this before.

Ms Nichols: As you know, it is one of those things that when you say it to politicians, they always smile and say, "Yes, what a cute idea." They do not take it very seriously.

In a more serious vein, perhaps it is something we could look at. I understand that in Australia, for example, there is such a thing and special services, in particular for children with special needs, are all handled through that. If there is a government prepared to take it on, I think all of our associations would be more than happy to work for that.

Mr Jackson: I just wanted you to know that it is our official position and one we embraced subsequent to our select education hearings. I very much share that as does the political party to which I attach myself.

I wanted to ask if it would be possible for the committee to be provided with copies of the report you referenced with respect to the post-21 experience for severely challenged individuals. Once receiving the report, we will examine it, but I had a concern that I wish to raise with you. I understand there is a form of discrimination that exists in legislation, beyond the one which you identify in 6. It has to do with the fact that academic programs are available to a student to completion of the school year in which their 21st birthday falls, but with the disabled community the programming ceases on their 21st birthday.

I have been just recently introduced to this. I wanted to do a little more homework on it before I raised it, but given that you have this report, maybe you can share with the committee this concern I am hearing about. It might also fall within the potential of recommendations—because it is a form of discrimination—which this committee might gravitate towards.

Ms Pollard: There was some reference made to the accessibility of programs varying from region to region. I think that goes also for the interpretation of whether people who are 21 and have a developmental handicap are allowed to stay and can continue. It seems to be a very discretionary thing, according to the board we are working with. There are many boards that allow the person to complete their year when they are 21. Some even continue on past 21, in all fairness to the boards. Others stick to the line of the 21st birthday, but not too many. I think it is more the other way around.

That is why we are very concerned about the education of all people with special needs, that the planning does

not go: "Oh, he's going to be 21. Where does he go now?" It should start for young people when they enter high school and working with the continued program, either through continuing ed of the boards, or with the Ministry of Colleges and Universities, or with the local community, whichever is the most appropriate.

Mr Jackson: I have no more questions. I have made two requests for information, if that could be noted: first, the report; second, that we get some clarification from either the Minister of Education, more appropriately, or Comsoc with respect to what deficiencies there are in the legislation which allow for this flexible rule—depending upon where a developmentally disabled person lives in this province determines the length of a certain form of support they receive. It is just a request for information to be tabled with the committee as soon as possible.

The Vice-Chair: I think we could make that request of Alison, to make further inquiries with respect to that type of information. Unless we deal with the request as specific to the minister, we would have to have a consensus on that in order to get a request like that to the minister. Sorry. We got clarification on that. You will get it.

Did you finish with your questioning?

Mr Jackson: In the interest of time. I have more questions, but I yield to some other members of the committee. It was a very good brief.

Mrs McLeod: Could I just add to that request for information, following up on Mr Jackson's questions, if it would not be too difficult, just so we know whether the Ministry of Education grants continue past certain ages and whether that is one of the factors in the continuation of programs.

The deinstitutionalization to date has had an initial and primary focus on children. That is where it moved most quickly. I think it has been quite marvellous over the years to watch the way in which the initial movement of children out of schools for those developmentally disabled—which I will not name so I can respect the need to change immediately the use of that old terminology—began with that integration into the regular school system and has moved to an integration at least part-time of the most severely developmentally disabled young people.

Recognizing the success that the school system has had, and I think it has been quite phenomenal, are there still some areas of real concern about the supports and programs that are in place in the school system? I am looking at under 21, because you identify in 8 that there is a concern about those over 21.

Ms Pollard: When we look at something like memorandum 81, an agreement between three ministries to provide supports and services and resources to youngsters with special needs, we continually see discrepancies throughout the province as to who is providing, in particular speech therapy. That is something that seems to have a lot of debate, whether that is provided by the Ministry of Education or the Ministry of Health through home care or what. That is one example where co-ordination really should be looked at very carefully.

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Ms Nichols: Further to that question, there are still boards in this province that choose to educate their youngsters with developmental disabilities in ways which most of us would not consider the most enabling, where there still are some special schools or a fair amount of separation. While it is obvious from our comments that we are not 100% on the integration-or-else bandwagon, we do support the government's philosophy of a full continuum of services. Nevertheless, we do feel there are many families with children who have developmental disabilities who simply do not have the same choices in terms of service delivery as other families do, and that really is something that in 1991 should not be happening to any family.

Mrs McLeod: Recognizing that there are some differences from area to area around the province, by and large you focused on the importance of training and post-secondary training opportunities. Are the supports there for classroom teachers and school personnel to manage the integration successfully?

Ms Nichols: I would say it is not there as adequately as it might be. I think there are many teachers who will certainly have the philosophical commitment to do a good job, but in many cases their training is not quite there and many of them do not have the support system in terms of support personnel, whether we look at speech pathologists or whether we are looking at psychologists, social workers, etc.

As a result, in some cases, boards will claim that they cannot afford the kind of integration they philosophically would like to put in place for their students. While one can accept and understand that, as a reason it really is not the right kind of thing in terms of the direction we want to go to as a province.

Mr Beer: It is nice to see you again. I believe your committee is focused at the elementary and secondary level, yet particularly at community colleges increasingly—universities as well, but I am thinking of some of the things I have seen going on at community colleges—we see a need. In order to help us, do you think it would be useful—perhaps it is going to happen—either to expand the mandate of your committee to go beyond the elementary and secondary, or do you think there is a need for a similar kind of body dealing with the post-secondary and, I suppose, other non-traditional education programs, dealing with those who are of an age where they are beyond the secondary program? Who is looking after that interest?

Ms Nichols: I do not think there is anybody looking at it in the sense of a co-ordinated look. This is purely my personal opinion because this is not something that we have discussed, but I would say that perhaps expanding the mandate of our committee or linking it with another committee that might look at such services would be the best way to go.

The reason I say that is that—some of you, I know, are aware that at the moment we have an interministerial task force looking at learning disabilities. One of the experiences I have had as a member of that task force, as we have

been consulting the community college special needs counsellors and just this afternoon the university special needs counsellors and earlier in the week I met with the apprenticeship branch, is that they all feel there is absolutely no connection among themselves, and also no connection between themselves and the school system in the sense of enabling students with special needs.

Certainly the community colleges and to somewhat lesser extent the universities are serving students with special needs, but if you look at who those students are, no university reports that they are serving students with any kind of developmental disability. Among the community colleges, I think there are only about five that even mention students with developmental disabilities when they talk about their special needs; I would say there are probably only two that actually have services.

Clearly, those things need to be expanded, but it cannot be done in isolation. One of the issues that keeps coming up at all these consultations is those transition periods in the lives of anybody but in particular students with special needs, which, in the opinion of these service deliverers, is particularly badly managed. If we set up a completely separate council just to look at post-secondary, I think we would be perpetuating that transition phase difficulty.

The ideal would be, as I say, either to expand the mandate of our council or alternatively have one that at times meets with our council so that there cannot be this kind of thing, this group doing something on this side and that group doing something on that side and they never talk to one another. More than for any other population, for students with special needs this kind of co-ordinated transition is tremendously important.

Ms Pollard: I would just like to add one bit. The Ministry of Education and the Ministry of Labour two years ago did a bridges to employment for students with disabilities. It talked about preparing the community with a SWT team, school-to-work transition team. That is one of the kinds of thing we really need to get in action. We need to have the ministries pulled together and the planning to be co-ordinated. It is not only to employment but some of the other opportunities, leisure and recreation programs.

If you look at nearly all of the books and pamphlets that have come out from the ministry within the last two years, including Transitions, the Ontario Child Health Study, Children at Risk, Workable by the Ontario council for the disabled, and the most recent one on children's safeguards in residential facilities, they are all—all, I repeat—talking about co-ordination and talking about the one-stop facility for the person or for the parents and guardians. I think that has to be something that is very highly recommended from this committee.

Ms Haec: A very quick question to you. I do appreciate some of the comments you have put forward. In light of some of my constituency work, some of the things you are talking about, particularly with people over the age of 21, really does have some impact.

I am concerned about item 10 on page 2 of your presentation. If we had bullet points it would be the first bullet point: "implementation of legislation still

outstanding." For someone fairly new to government, I am not sure when you say "still outstanding"—you could be talking for the last 25 years.

Ms Nichols: Only five years.

Ms Haeck: Okay. Have you any particular bills uppermost in your mind? You are probably happy I asked that.

Ms Nichols: What we are talking about here, as you will no doubt recall, is that in 1980 there was legislation introduced called Bill 82 which was the 1980 amendment to the Education Act. That became law, fully implemented, as of 1 September 1985. The legislation that was introduced in 1980 contained a number of segments which related specifically to the implementation phase. In particular, it contained a number of segments which are referred to as the segments for the trainable retarded.

In January 1986, the then Minister of Education circulated a consultation document to the world at large, with a deadline of 30 June 1986, to recommend amendments and changes in that legislation to bring it up to date in light of the five years of implementation. There was certainly total agreement among all consulted that all those segments relating to the trainable retarded should be eliminated and that those students should not only have a new designation but that our way of working with them and supporting them should really be different; plus there were a number of other items there with unanimity that they should be amended.

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In the five years that have elapsed since January 1986, that legislation is still outstanding and it has created some very significant problems, in our opinion, in terms of where the school boards see the government of Ontario standing on some of the issues around special education. We recognize that it perhaps is not your primary mandate to deal with educational legislation, but as a council we feel that we simply raise this issue with any group and any committee and any body that has a chance to comment because we do feel that it has created some significant problems for families and for individuals.

After all, students who were in grade 9 when the full implementation started in September 1985 have already left the school system in many cases before those amendments have actually been introduced and discussed in the Legislature. That is really what we are talking about. I do not think it is particularly hidden that there are many people, like our association, who feel very frustrated that it is just never coming right down to a fact.

The Vice-Chair: I am afraid we have run out of time and we need to move on to the next presentation.

Mr Malkowski: I have a very brief comment.

The Vice-Chair: Very, very briefly. We have 30 seconds left.

Mr Malkowski: I am wondering if you are involved with the People First organization.

Ms Pollard: Certainly I am, through being a representative of Ontario Association for Community Living. People First is housed in the OACL building, and we try to have as close a representation as we can with them. Did

you have some specific question that you wanted to ask about our relationship with People First? It is an independent body.

Mr Malkowski: No, not at all. Because of the time restraints that we have, no.

The Vice-Chair: Thank you very much for making your presentation. We will have to move right along.

HOME AGAIN RESIDENTIAL PROGRAMS FOR THE HANDICAPPED

The Vice-Chair: I call upon the Home Again Residential Programs for the Handicapped. Margaret Price, the executive director, and Andrew Faas, board member, please come forward. Welcome to the committee. Introduce yourselves, if you will. As I remind each of the presenters, you have half an hour to make your presentation and you can divide that in whatever fashion you deem fit. If you would like questions to be asked at some segment, please allow for time for questions.

Mr Faas: Thank you very much. My name is Andrew Faas. I am a volunteer member of the board of directors. I think it is important for this committee to hear from the volunteer sector as well.

I am not unfamiliar with the volunteer sector, particularly in institutions that are funded by the Ontario government. I have been on the board of directors of Home Again for the last seven years. Also in my volunteer life, I am a member of the board of governors at Mount Sinai Hospital, a member of the board of directors of the Juvenile Diabetes Association, and the immediate past chairman of the board of George Brown College of Applied Arts and Technology. In my part-time professional life, I am currently the executive vice-president of National Grocers Ltd, and that is the Ontario arm of Loblaw Companies Ltd.

With me is Margaret Price, who is the full-time executive director of the organization that we are representing here today.

We appreciate the opportunity to meet with this committee, to provide both from a volunteer perspective and an operational perspective our viewpoint and to make recommendations to you relative to the multi-year plan of providing community living for people with developmental handicaps.

First, I should outline what Home Again is. In 1983 the provincial government announced the closure of Ark Eden Nursing Home in Stroud. Unfortunately, the parents were not consulted about the closure and were faced with a situation of uncertainty as it relates to their children's future. As a result, the parents of the 42 children at Ark Eden decided to set up a parent group and at that time were encouraged by a coalition of advocacy groups to explore the possibility of integrating their children into a community setting.

Today the organization, which is governed by a volunteer board of directors comprised of representatives of families and the community, serves 23 children and young adults in four small residential locations in North York. Each of our residents has physical and mental handicaps requiring constant, 24-hour-a-day staffing support.

Families are seen as the mainstay in the life of our residents, and the importance of families is central to the philosophy of governing Home Again's provision of service.

Supported learning opportunities are provided in a variety of environments so that our residents can be active participants in their homes and communities as friends and family members. Our day program at Home Again presents stimulating activities for our clients so as to motivate them to learn new skills and to appreciate and enjoy various facets of life and learning, providing many varied life experiences and developmental activities.

Home Again also tried to help answer the challenge of the province of Ontario's multi-year plan by encouraging other families fearful of community placement for their children through our fostering efforts, helping others create, in our view, a better alternative than institutionalization for their family members.

When we compare our residents to what they were like in 1983, the benefits of the changed environment are beyond belief. Children and young adults who previously lived a life devoid of exercise and stimulation of both body and mind, with almost zero growth opportunity, are now enjoying various life and developmental experiences which go well beyond what their parents or those who assessed them professionally could have dreamed possible.

To give you one example, a young man came to Home Again in May 1984 from a nursing home which was being closed. The following terminology was used to describe him, and I will quote, "Aggressive, hyperactive, requires nursing care, non-ambulatory, needs puréed food, drools profusely." Today he eats a regular diet, fully independent of others helping him. He learned to walk in the summer of 1989. He can pour his own drink. He uses signs to communicate food and drink. He makes choices of where and when he wants to go somewhere. He graduated from a school program and shared in the celebration of such an occasion. He has friends and they go out partying and playing arcade games. He was interviewed and made the front page of the *Globe and Mail*. He has played a major role in advocating on behalf of many young people who are still existing as he did at one point in his life.

Based on the very positive benefits that I have witnessed in providing community living opportunities, I believe in the philosophy espoused in the multi-year plan. I must confess, however, some discomfort in the direction that is being taken and concern as to whether the multi-year plan can be successful in the long term. My sense of discomfort centres around a number of basic concerns which I will outline.

My first concern is the government's long-term commitment to community living. While parents are being encouraged to deinstitutionalize their child, there is no long-term guarantee that a future government will not discontinue its support of community living. Based on everything I have read, I cannot see any assurance that parents or family members could find that their family member could not be displaced from a group home similar to what our families were faced with when Ark Eden closed.

I am sure that families who made a decision to keep their children at home 15, 20, 25 or 30 years ago are perhaps regretting that decision now that they are less able to care for their own son or daughter and they see greater priority for support is being given to children who were placed in an institutional setting. We must ensure that in 15, 20 or 25 years parents who are now deciding to place their children in the community from an institutional setting do not have the same regret.

This concern is reinforced when we see some families whose children presently reside in government-funded institutions being told to take their children home to make room for children who are at high risk and presently residing in acute care hospitals. Specifically, children at Bloorview are being displaced to make room for children at Sick Kids who are on low-flow oxygen. Also, children in group homes under the Child and Family Services Act are only funded up to age 18. They must then move to an adult residence. Unfortunately, there are no vacancies.

1650

My second concern is our ability to provide the necessary support from a staffing perspective. This concern goes beyond any pay equity issues, that is, compensation in community settings versus institutions. My concern is really based on questioning whether or not we can attract and retain the necessary qualified and dedicated professionals to provide the long-term support that is required. Regardless of the economic environment, demographics tell us we are going to have a major shortage of workers. This means that we in the community living environment will have to compete not only with institutions but with other sectors as well.

It is well known in a variety of sectors that the pay is low. This has led to a drastic reduction in enrolment in community college programs related to service provision for persons who are developmentally handicapped. I believe that there were only 19 graduates last year. The ability to attract and retain professionals to work in our environment will have to be the number one priority. Answers to job compensation and job enrichment must be found.

If answers to these issues are not found, it is quite conceivable that we will be forced to rethink the deinstitutionalization strategy in the not-too-distant future. The hard reality from a practical perspective is that institutions do provide economies and efficiencies of scale and have mixed feelings as to whether we should risk the implications of transferring people back into an institutional environment for practical reasons after they have enjoyed the benefits of what community living has to offer because of this practical implication. This concern is reinforced when we see some agencies in York region close group homes on weekends because of staff shortages.

My third concern is what I perceive to be a lack of strategic co-ordination and consistency. Let me explain.

First, the multi-year plan reflects a series of philosophical statements versus a strategic plan. The multi-year plan does not outline specific standards that are expected. Too much is open to interpretation without specific direction on things like: What is "adequate"? What is "appropriate"?

and by whose definitions? Normalized environments for whom? Meaningful work? The plan seems to be loaded with jargon.

Second, the plan appears reactionary, geared more to dealing with resolving immediate situations such as institutional closures. The priorities must be challenged.

Third, understanding and addressing regional differences, particularly as they apply to capital projects, we see little consideration being given to the fact that services provided in large urban areas such as Toronto versus small communities are more expensive.

Fourth, the lack of specific commitment to the developmental needs of existing agencies—again the philosophical commitment is there but we find that as an agency we have to beg for this type of support.

Fifth, the government bureaucracy needs to be tackled. For example, differing regulations from ministry to ministry and provincial to local government create inefficiencies, and a disproportionate amount of our staff's time, attention and resources is spent in dealing with indirect activity to the detriment of the people who are affected.

An example is the requirement by the ministry to seek public health approval to pass inspection. Public health argues every year that it does not have to do this. Reluctantly, they respond to us, but if they did not do this for us, we would not be able to pass inspection.

Another example is when we were installing elevators in two of our homes. Three government agencies were involved, each with a different viewpoint. This was not resolved until the day the residents arrived in their new home. The inability to obtain funds without argument in order to meet the requirements of other ministries and local government limits our ability to provide support more efficiently.

Sixth, the strategic plan does not address the long-awaited revision to government legislation for the developmentally handicapped adult, similar to the revision in legislation for children's services on providing greater flexibility, and a recognition for the rights and autonomies of children and families.

My fourth concern relates to our employer-employee relationships, which appear unclear. As a volunteer board of directors of a non-profit organization 100% supported by government funds—I should clarify that these are necessary funds deemed by government; we do fund-raise or other support services—we do question our effectiveness as an employer, particularly as it relates to employee compensation.

In collective bargaining, our ability is limited as there is a risk that funding may not match what we are required to provide in order to satisfy the needs and requirements of our employees and to avoid a dispute in responding to them. Also, for pay equity purposes, we understand that there is a ruling that employees in an environment such as ours are deemed to be government employees. These issues, in our view, take away a significant amount of self-direction that is required for people such as myself to feel comfortable operating as a volunteer director.

I have outlined a few examples of where thinking needs to be done and issues need to be resolved to ensure

that the multi-year plan survives in the long term. It is very encouraging for us to see the government seeking viewpoints from a greater constituency, as it was our view previously that people who were actually the most affected by the multi-year plan had very little to say on its direction and implementation.

We understand that it is important to hear from groups such as the Ontario Association for Community Living, OPSEU, the Federation of Ontario Facility Liaison Groups and People First. We suggest, however, that you do extend your information base to include a greater representation of direct family input, as we believe that the larger group perhaps now represents service providers versus families who play a smaller role within these larger institutions than is perceived by government or the public and therefore their voice may not be as loud as what it should be.

The Vice-Chair: Thank you for your presentation. I believe that you have been with us for some of the presentations this afternoon. It is useful to hear some of the examples of what your organization has tried to do and what was put forward by Mr Clutterbuck in regard to the increasing role that parents wish to see for themselves in developing different models of service and your reminder in the last paragraph that we as legislators need to be mindful that those groups are out there that may be involved in some of the broader provincial organizations, but none the less may have a different point of view.

I appreciate that in the time frame we have of some 10 hours we are not really able to encompass all of the different groups, but I think one of the reasons that we wanted you to be here today was because we knew that you would probably express that point of view. I think that it is something that we have to keep bringing forward.

I would like to say that I would hope that in all three parties there is absolutely no reconsideration of the goals and objectives of the multi-year plan. In regard to your point of somehow really stressing that and having a clearer statement so that those parents know that their children, young adults, who may well be with us for another 15, 20, 30 years, in fact will be protected and properly looked after, I would hope that somewhere in our report we would make that a very clear point of view. I think if that does not appear to be stated in various government statements, it certainly is something that ought to be and that this committee would support.

The question that I wanted to raise with you is around the multi-year plan and your comment about it appearing to be reactionary in dealing with particular situations such as institutional closures. One of the issues, and it has been mentioned earlier, has been around the balance between moving people out of institutions and dealing with those developmentally handicapped individuals who are in our communities, who have been in our communities.

My sense when I was on the other side of the House was that I do not know if we had as much of an awareness of how many people were there already who had been living with their families because the family or that particular community just accepted that as being the norm. As the policy developed, the multi-year plan which we began to implement, there were simply more people in

the community, and then as the parents got older and were looking for services, there was this tension between those in the institutions and those in the communities.

1700

Could you give us some advice on how you see us trying to work with that conundrum? Obviously, there are limited dollars in all of this. What is your sense of that demand that is there now, that is in the community, developmentally handicapped young people, adults who had never been in an institution but were for a variety of reasons, aging of parents or just wanting to be on their own—how do we address that?

Mr Faas: On your point in terms of being somewhat surprised at the numbers, I would suggest that you do more research. Your point relative to just becoming aware of the numbers of people that require that kind of support, I think, is a first step to finding out just the degree to which the service is required. My involvement with this group is only seven years old. I look at it on the basis of the more I find out and the more I hear about this, sometimes I say to myself, "Jeez, I wish I didn't know as much because I know the problem is immense."

Our point, I think, or recommendation to you is to understand that a little bit better, and from a practical perspective, I think you have to establish some parameters and establish some priorities. I know that is one of the most difficult things to do because everyone you talk to who requires that support or people who represent people who require that kind of support will have certain biases. I know that is difficult.

Your comment relative to family participation hits home with me as well. I am a volunteer director. I come from the business sector and I am fiscally responsible with my other directors, but it is always revealing when I hear from parents. It is easier making a business decision than it is to make a decision relative to some of the issues we are faced with in a group home.

Margaret, you may want to add to that.

Ms Price: I am a parent of a developmentally handicapped child and I guess, in response to your question, 35 years ago it was parents coming together that created the very system we have now. I think as government, seeking input, you probably would be wise to facilitate some sort of mechanism where families, instead of seeing themselves on opposite sides of the fence, can come together. We can be quite creative planners.

That may be an avenue and that, I think, speaks to the issue of not always hearing from the same groups. It is not that their points are not valid. Back when the issue around nursing homes came up, I was a board member for the Ontario Association for Community Living, and yes, many of the young people who lived in nursing homes were living in deplorable conditions. If we were going to get a point across, it has to be those people in most need.

If you look back through the documentation, we were saying clearly then that there are many people living in the community today and tomorrow who are going to require this sort of support. I think there is a variety of avenues.

Mr Hope: I want to thank you both for coming today. In my new role in the government as parliamentary assistant to the Minister of Community and Social Services, have been out doing exactly what you have been saying, have been talking to parents who have raised their child and now the child may be not a child but an adult, 21 years old, wanting to enter life on his own. They are looking for access and they are scared because it is letting go of apron strings, as you may call it.

I am glad you brought out some points on your number 3(a). It is being reflected as a plan versus a vision, and I think you clearly put that vision out.

As I have been touring around talking to different groups and to parents, and I have been to the institution in the southwest regional centre, which is a neighbouring institution to one of the ridings beside me, I have seen these developmental changes over there that are adapting people to community living.

The part I am really scared of—I knew the number exist—is those parents who did not want to put their child in an institution, who raised him and are now saying: "I have two smaller children I would like to spend a little bit of time with and a husband I would like to spend a little bit of time with. We need help getting him into that"—I think Cam put it quite clearly a little while ago, not necessarily concentrating on those just in institutions, but we have those who live in homes and they may be in rest homes, have been hidden away in some group that is not getting adequate care and developmental change.

I think we have to focus on it. I thought I was the only one thinking about some of the points you have put out today. I think, yes, we need a directional change. I think we have to make sure it is going to be a long-term effect just want to thank you for some of the ideas you have shared today.

Mr White: My question is not a broad one, but rather more specific. On your point on page 4, quite often a small agency has a lack of resources in terms of its staffing and its board of directors. When you say you have only been involved for seven years, I think that is actually, relatively speaking, a fairly lengthy commitment. A situation such as you are in, as I think you mentioned, is often a different circumstance from being on a business board. I see these as being tremendous problems in terms of the developmental needs of your agency as well as your servicing the clientele. When you say that we have to beg for this type of support, what kind of support do you think your agency might benefit from in terms of its developmental needs both at the board of directors level and at the staffing level?

Ms Price: I can certainly speak of the staffing level. The going rate around training for a front-line staff member is \$125 per fiscal year. The requirement says that cardiopulmonary resuscitation and first aid shall be taken annually. The turnover rate for a lot of agencies—not out of thank goodness—is about 50% a year, and it costs \$90. If you have had someone come in, you provide that sort of training, they have been there one year and someone

comes in and replaces them. You are already in a deficit position training-wise at the end of that fiscal year.

There are all sorts of wonderful forums and experts in the field who provide inspiration, direction, all of that sort of thing, but very few of them are \$20 for an all-day session. We do not have the money to do that sort of thing. So I think it is an area in particular, working with people who have severe handicapping conditions, where the more training you can provide someone, the better in terms of whether or not they last as employees in the long term. It is not something that is recognized. Every year, when we sit down to negotiate budgets, we have the same discussion. Every year it is the last thing on the list.

Mr Jackson: Margaret and Andrew, thank you for an excellent brief. I want to zero in on one of your outstanding points. On page 3, you talk about transferring from community living settings back into institutional settings. This concern is reinforced when we see some agencies in the York region close group homes on weekends because of staff shortages. That should cause an awful lot of concern and alarm. I just wondered to what extent you can tell us what is becoming more prevalent.

I should tell you that I am 18 years a member of the community living association, so I am very involved. I thought I had been tracking very carefully returning to institutional settings because of inappropriate placement or mutual agreement. I understand that. You are supplying something entirely different from what we heard last week looking at children's mental health access and the inter-funding crises are causing client shifts that are inappropriate. Could you expand on that. We are not hearing about this. I had not as someone who thought he was up on this issue. I would like it if you could comment more specifically on this.

Mr Faas: On the comment relative to the York region closing on weekends, or our suggestion that we could move back into—

Mr Jackson: Both. I thought it was an affirmative statement that in fact it is occurring, not just that it could occur.

Mr Faas: It is occurring.

Mr Jackson: That is the first thing I understood. Second, you gave us an example of how prevalent. Could you expand on that. Is it because of implementing pay equity or other provincial initiatives?

Mr Faas: Marg mentioned that fortunately we were not running in a 50% turnover rate, but a couple of years ago we had a 100% turnover rate. We had to address them in a very creative way, one dealing with pay equity as between group homes versus the institutions, and the other to creatively look at ways and means to enrich their work environment through raising funds to provide some personal developmental opportunities for those people.

Our argument, though, and it is a statement that I make, I guess, from more of a business perspective, is that an institution does provide greater economies of scale. If there are not enough people working in a group home setting, for whatever reason, we may have to relook at the strategy and go back to an institutional setting to provide just the basic needs: feeding them and housing them. It is from a practical perspective that we argue that way, and the reality that it is occurring is the York example where they cannot keep people there on the weekends because they do not have enough staff to take care of them. We fortunately are not in that situation to date, but we very well could be.

The Vice-Chair: I do not wish to cut people off like this. Unfortunately, we have come to the end of the time allotted to your presentation. I am sorry to have to do this, but we have to end it here.

Members of the committee, can I remind you that tomorrow is a 9 o'clock start time and we will proceed promptly at 9 o'clock, whether all members are here or not.

The committee adjourned at 1712.

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social development**

Service mandate for
developmentally handicapped

**Assemblée législative
de l'Ontario**

Première session, 35^e législature

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des débats
(Hansard)**

Le mardi 22 janvier 1991

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affaires sociales**

Mandat de services relatifs
aux déficiences mentales



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 22 January 1991

The committee met at 0905 in committee room 2.

SERVICE MANDATE FOR DEVELOPMENTALLY HANDICAPPED

Resuming consideration of the designated matter, pursuant to standing order 123, evaluation of service mandate for individuals with developmental handicaps—multi-year plan.

ONTARIO ASSOCIATION FOR COMMUNITY LIVING

The Vice-Chair: Members of the committee, our first group of presenters is the Ontario Association for Community Living. Welcome. We have you scheduled to be on between 9 and 12. I know there are a variety of regional groups that will be with you today and you can divide that me up as you have probably already decided. I will let you proceed in the way you would like. If you would like to start, we are here to listen.

Mr Zwerver: Following up on your comment, what we thought we might do this morning is to break up our presentation by some of the areas that the committee is looking at specifically. We have a number of people representing parents and service providers across the province of Ontario, people who have specific knowledge about some key issues that I know are of interest to the committee.

What we will do at the beginning is we will have an introduction by our president, Nancy Stone. I am Harry Zwerver, the executive director for the Ontario Association for Community Living. Nancy Stone is our president and she is from Niagara Falls, Ontario.

Following that, we will have a couple of people talk about the process of deinstitutionalization and planning, followed by a presentation on family support and community development. That will be followed by a short presentation on resources and the area of employment, especially supportive employment, and then a presentation on advocacy. Then we will have some time for a wrapup after that.

The suggestion that was made—I am open to comments, obviously, around that—was that what we would do is take about 10 minutes for each of the presentations and leave about 20 minutes for questions and then move on to the next area, unless of course we get some real juice going around something and that may vary, but that is the suggestion at this point if that meets with your approval.

The Vice-Chair: Absolutely.

Mr Zwerver: Okay. I would like to introduce Nancy Stone, our president, who is going to give you a little bit of background about the Ontario Association for Community Living and then I will make some comments.

Ms Stone: It is nice to be here this morning. I was having heart palpitations on the way up University Avenue, afraid I was going to be late.

OACL is a federation of 119 local associations across the province. They vary in size and in service delivery. We have over 21,000 members just as part of those associations. OACL and our local associations work with and on behalf of persons with developmental handicaps.

The very first local association was organized in 1948 by parents and families of persons with developmental handicaps because of the lack of services in communities. We are very much a grass-roots organization and over the years those parents who began the movement have remained part of it. We have evolved over those 43 years into a sophisticated network of service delivery and a strong advocacy movement to address issues of importance for persons with developmental handicaps.

The goal of OACL is that all persons live in a state of dignity, share in all elements of living in the community and have the opportunity to participate effectively. This goal envisions a society in which the innate value of each one of its people is honoured and protected. The dignity and self-respect that its people enjoy in their respective communities are the result of sharing and shouldering the responsibility of welcoming and supporting all members of the community without discrimination.

This evolves from our "Goal and Vision Statement." This is part of it and I suspect you probably have copies of it. We are presenting issues this morning around deinstitutionalization and the effects of Challenges and Opportunities. The issues around those with developmental handicaps are very much tied to that deinstitutionalization initiative by government, so that other aspects of persons who live in communities are also affected by this document. So the issues affect not only those in institutions, but also those who live in communities. We cannot address one without the other and certainly they rely on each other.

We recognize the importance of smaller dwelling units and options for persons with developmental handicaps, choices and a better quality of life. We need support services in place for people from community and institutional settings. Special services at home is one program that meets a great need for people both in the community and those who are coming back from institutions. I see special services at home as a preventive kind of program and definitely to be considered a primary program in the plan.

We need proper planning, individualized with involvement by the individual, his family, the community and the service provider. We need proper and sufficient resources. This encompasses a great deal, very many items, one of which is wage comparability. We feel this is a very important part of it. In the past and right at this moment in

Ontario, those who are working in agencies, in communities and part of the local associations are paid on average about 25% to 30% less than those who are working in institutional settings. We very much feel that we must look at competitive wages for those people for several reasons. I am sure the other people will go into this a little further, but it enables quality programs to operate in communities.

We also need those employees who are now part of the institutional setting and we cannot compete at this point with the wage level they attain within the institutions, but we need those people in communities when the deinstitutionalization plan comes into effect. So wage comparability has many overreaching issues around it. We need proper planning and sufficient support. I think I have said that. That is also related, obviously, to resources. We need day programs and supported employment, opportunities for choice for people, for those older people who choose not to be employed and who might need some day programs and so on.

We have many issues of importance to persons with developmental handicaps. OACL is looking at these issues day by day and they all relate. I think it is very difficult to look at some issues and not to look at all, one of which is advocacy. Your government is looking at that very closely. Guardianship is another really important area. The special services at home I have referred to just a little bit. Education continues to be important to persons with developmental handicaps. Having an integrated education is extremely important. Boarding homes and other forms of residential care that are unregulated are very much on our agenda at all times. We have other issues that probably you will not be touching on, but that we feel it is important to point out.

That is my little beginning process. If you have any questions, I would be happy to answer. Perhaps Harry can add to what I have said.

Mr Zwerver: I think it is very timely that the committee is looking at Challenges and Opportunities at this stage, because we are halfway through the first phase of the multi-year plan. The key ingredient in the multi-year plan is obviously to provide adequate community-based alternatives to people who have been living in institutional settings. As an association and as people who are working with and on behalf of individuals who have been labelled by our society, we continue to be very excited about those possibilities, but we do have a lot of concerns. Some of those are ones that Nancy has already referred to.

I think the core issue really for us continues to be the need to have adequate funding to develop community support alternatives, whether they are in the areas of housing, employment, education or recreation. We have many families who presently are on waiting lists for services in the community. Families are at risk. People do not know where to turn.

The focus for much of what has been happening so far in deinstitutionalization has focused on providing services within a service structure. We also recognize that there are a lot of concerns and fears that are expressed by parents of individuals who are presently living in institutions. They are concerned about the risk for their sons and daughters

when they move back into the community. We know the concerns of institutional workers, who are very concerned about what their future employment is going to be about. They are concerned about whether there is a place for them in the system that is evolving.

Those are two legitimate concerns. However, they should not be used as reasons to maintain what is clearly an inadequate system of institutional care. We think all of these are really opportunities to indicate the level of support that is available to truly integrate people into community. Integrating people into community and the whole concept of community living is not just about moving somebody into the community.

We talk a lot, and I am sure you have already heard some of the statistics about how many people have moved from institutions into community and somehow we equate that with community living. Our position is that this is one element of community living, but unless someone is truly integrated into that community, he can be as isolated in that community as he was when he was living in the institution.

It is not about developing artificial alternatives either. It is about how we use the resources, the agencies, the churches, the social clubs, all of the political and social structure of the community, to make people truly feel part of that community regardless of what the label is. We are not just talking about people who are developmentally handicapped. It applies to anyone who has been labelled by society. This is really about, how do you ensure true community living alternatives?

The other theme that goes along with this is really, I think, the need to move from looking at all of this in a context of services to supports, really starting with the person, starting with that person's abilities, that person's skills, that person's interests rather than always looking at the issue of need.

The way in which we develop supports looks and feels very different when we start with the individual and what abilities he or she has rather than when we look at someone by label and say, "Here's another half a dozen people who need certain kinds of services in the community." I think there is a real challenge for us who are in the business of providing services as well as for government which is looking at ways in which to develop and support adequate networks within the broader community as well.

I think there is a real tendency by us in society to hang labels on people. We start with one label and then we add another label to that, so now we have people who are dually diagnosed and we have people who are triply diagnosed. Somehow whichever label it is that the person starts with tends to determine where the individual gets streamed by the service system in our society.

The mental health system does not know how to deal with someone who has a developmental handicap. The services for people who have been labelled developmentally handicapped claim to not be able to deal with the person who has an intellectual disability or has a mental health handicap, and it just goes on and on. I think it is time for us to really look at the person as a whole human being and take a look at how that person can be

be supported, regardless of what that label is. I know the government is looking at that in terms of some of the long-term care alternatives, but we believe it needs to happen much more quickly and needs to be part of planning to move people into community.

We believe we need to ensure that people who have disabilities or who have been labelled, like everyone else within the community, must have an opportunity to make real choices and to be able to avail themselves of real opportunities, choices about where to live, where to work, with whom to spend time, to make friends, to contribute, to go to places, to do things, to be paid for work and to continually be able to acquire skills as part of being in the community and being part of community living.

Our existing systems of support, we would suggest to you, are underfunded. Our planning mechanisms are inconsistent. They tend to be underco-ordinated and they tend to still be very service oriented. So it is important for us as we move through this stage of examining the multi-year plan to find a way of bringing this back to focus and to move people out of institutions into something that truly is community and that truly can support people who need to be part of our community and part of our society.

Having said all that, what I would like to do is to introduce to you Eva McPhail. Mrs McPhail is a parent of a young man who came out of an institution. She is going to tell you a little bit about her story and the kind of struggles that has been for her family. I am also going to ask Maureen Brown, who is the chairman of the executive director's co-ordinating committee, to come up here. She is the executive director for the St Catharines Association for Community Living. She will talk a little bit about how planning is working or not working in various parts of the province for people who are moving out of schedule 1 facilities.

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The Vice-Chair: Point of order or question?

Mrs McLeod: Actually to get a sense of the flow of the morning, if I can just take a minute to do that and perhaps just to set our morning's discussion in the context that I hope it can take. As you know, when we had asked that this be a subject to be considered at committee, it was when there was a period of uncertainty about the future of the deinstitutionalization. I think there is less uncertainty now and that puts our committee hearings under a somewhat different context, because I think on all sides there is a commitment to continue with the deinstitutionalization that people believe is important and that it will go ahead, but it is also seen by the government to be equally important that the plans be reviewed. I think all of us would concur that this is always a good idea.

I guess the concern I have is that I would want to see our deliberations in the committee be a constructive contribution to that review and also to the progress of deinstitutionalization. That means obviously we need to identify the problems, because there are real concerns, as you have said, and we can identify those and get a sense of what has to be addressed for the deinstitutionalization to be successful. That will work well, but I know there is a

tendency for us all to focus on the problems to the point where sometimes we can be so overwhelmed by the problems that it almost creates a sense of helplessness and paralysis that could almost have a backlash on the deinstitutionalization program itself. I am hoping that what we will do this morning is be able to see what is working as well as where the problems are.

Is that the sense of what you wanted to bring to it? Could you tell us when you think different areas should be questioned on our part, the flow you would like to have to the morning.

Mr Zwerver: Obviously, this is your time to ask us and we will provide you with information as we go along. The suggestion that was made was that we look at a number of components of the challenge that is before the committee starting with the planning process and the process of deinstitutionalization from a number of different perspectives, then move into the area of family support and community development, then the whole issue of resources and employment and then following that with some discussions about advocacy.

It is not our intention, certainly, to focus on negatives. I think what we are wanting to do is to share with you the experience of the multi-year plan to date, to talk about the challenges that are there, as I said in my introductory comments. We are very excited about what has happened, but there are concerns and I think it is the concerns that you as a committee are wanting to focus on because there is an opportunity I believe, at this juncture, to really take hold of some of these and maybe provide an opportunity to shift.

In some cases, it is a very subtle shift and I think in some cases it is really a different kind of emphasis. So my point about the process of deinstitutionalization and moving people into the community is around that. I think we are very excited about people moving into the community. A lot of good planning is going on. It is inconsistent at this point and that is part of doing things differently obviously. At the same time, there are some really interesting things that are happening across the province. The key issue is making sure that we do not accept as a fact that just because you move someone from place A to place B and the place has fewer beds than where he came from that somehow we have accomplished something called community living. I think it is a very critical theme that we will keep talking about as we go through the presentation this morning.

Mr Jackson: Just as Mrs McLeod has indicated, I do not think she can speak for all of us in terms of the lack of concern level with the direction the multi-year plan is going. I have some serious concerns about it and I am not encouraged at all by the hastily prepared response that we did receive from the minister in terms of putting the multi-year plan back on the rails. So I very much would hope that given that the multi-year plan has a time framework to work within, because we are not having the ministry come before us for cross-examination, we only have access to you as the primary agency, if I can use that word, or association that can suggest to us that the benchmarks are not being met.

It is very important that you understand the concerns I have and that the Conservative caucus has. We are going into a recessionary period. We have not received one single statement from the minister with respect to capital commitment. We have only received personal statements of assurance. I have been around here long enough to know exactly what that means. I just wanted to suggest that I do not share completely the view, as Mrs McLeod has stylized it—

Mrs McLeod: Do not misinterpret what I said.

Mr Jackson: I did not misinterpret it. You said everybody was in accord that this is the direction we are going in. I do not believe that is the direction we are going in. One deputation yesterday indicated how pleased they were that the minister had put the plan on hold and done all this research and investigation during the course of 30 days and was satisfied now that everything was back on the rails. I thought that was an incredibly naïve statement on the part of the deputation, but it was allowed to just float around as though in fact there was some meaningful review and analysis and the minister and her government were completely satisfied.

I want to stress to you that although I have been a member of the association for 17 years, I know that it is worth while that we have a stronger understanding of your work. I think it is also incredibly important, when I look at the list of people presenting to us, that we look to you to give us the specifics of the areas in which we are not on target with the multi-year plan, without pointing a finger at the previous government or the government before that or the government of the day; just simply, the plan is a good one and where are we along the plan, what kind of capital dollars are required, and if they have not flowed for three years, why have they not flowed for three years, and what has that meant to your families.

I want to put that on the record because I feel very strongly about that and I do not want this to be just a cozy, fuzzy review.

Mr Owens: Just a brief comment without getting into a discussion with Mr Jackson about what he said she said. I think his final point is well taken, that it is up to the consumers to give this committee direction as to where we can assist them, where they feel the process of review should take place. I do not think it was the minister's intent in any way, shape or form to indicate that the review process was finished and, second, that everything was hunky-dory and we will just proceed on schedule.

Again, as Mr Jackson has pointed out, I think it is up to the witnesses who come before us today to indicate where the pitfalls have been, the pitfalls you foresee perhaps around staffing, perhaps around capital budgeting and issues like that.

The Vice-Chair: We are indeed here to listen to what you have to say. If you would like to proceed with other presenters, it is entirely up to you how you want to divide this period. If you want to allow us time to ask questions, again, that is your decision. We are in your hands in terms of how you want to proceed and how you want to divide this time up. Please do what you feel is necessary.

Mr Zwerver: Thank you. We have made a suggestion obviously as to how we might do this and our sense is that within each of those areas, given the fact that there will be a brief presentation, there will be an opportunity for you then to ask the specific questions that you feel will help you in your work as a committee, and if there are things that are not clear, then by all means make sure that you probe and push us. We will either give you our best shot at an answer or, if necessary, we will leave here today, pull together further information and submit that to you if that is in order. We are basically at your disposal to help you with the challenge that is before you.

The Vice-Chair: I will proceed on the basis then that you will indicate when you have finished a presentation and then I will proceed to ask for questions from members of the committee. Please identify yourselves as you come to the microphone.

0930

Mrs McPhail: I am Eva McPhail. I have come today prepared to talk a little bit about my child Paul. I have brought a picture of him that I would like to pass around.

It is a real honour for me to be here with you today. I would like to share with you some of my experiences as a parent of a profoundly mentally retarded young man named Paul. This is a story about change: change in Paul's life, change in the lives of Paul's parents and family. It is a story of advocacy and how advocacy works to change situations and people.

First, I would like to tell you a little about Paul's early years. In medical terms, my son is described as being profoundly mentally retarded, hydrocephalic and partially paralysed. He is purported to be epileptic. He is prone to urinary tract infections, prone to tonsillitis and prone to eye infections. He is anaemic, has chronic gastric upset and some known food allergies. He is doubly incontinent and has his own seating apparatus, as he has no use of his lower limbs. He is tactile defensive, hypersensitive to heat and cold, he is visually impaired and has no formal mode of communication. What does this really mean?

To his family, which consists of a mom, a dad, an older sister, a twin brother, a younger brother and two grandmothers, Paul is a medical miracle. At birth, he was six weeks premature and weighed four pounds. He was the first-born of twins. He was given a 50% chance to live. At two weeks of age, he suffered a petit mal seizure. The doctors discovered he had contracted meningitis, which led to hydrocephalus. They gave Paul an optimistic 30% chance to survive. He survived.

By age three, Paul had undergone more than 39 brain operations to install and then correct malfunctioning shunts and tubes. At that stage, his doctor refused to operate any further and he suggested that Paul might live three months longer. To facilitate a final separation for us, his family, the doctor suggested that we should place Paul in a chronic care nursing home. The doctor phoned to arrange these services for us.

Surrey Place Centre contacted us and strongly urged us to place Paul immediately in a care facility. After months of agonizing decision-making, I finally agreed that Paul

name could be referred for placement. We then learned that Paul's name was on a waiting list of 200 other young people, and perhaps a place would be found for him within a couple of years.

Paul was first placed in a nursing home near Barrie. On visiting the home, we were appalled. The building was small, cramped, overcrowded and smelly. Most of the residents were completely bedridden and none were expected to live long. Visiting Paul was almost worse than never seeing him again.

Through a friend of my mum, we located a children's home close to our native town and we were able to transfer Paul there. Throughout Paul's many medical crises and placement process we, the parents, felt we had no control over any of the decisions. I was regarded as stubborn and unco-operative as I refused immediately to place my child at the whim of the professional.

Paul moved to Sunnydale Nursing Home in Sunderland in 1975. He was six years old. This seemed to herald a time of peace and happiness for all of us. The home was large and airy. We saw few terminally ill children of the 72 here. The children seemed happy, clean and well cared for. The staff were kind, caring and open to sharing with the families. The staff treated Paul as a normal boy and they loved him. They welcomed visits from the family at any time. This home included community volunteers, and the children here were included in local parades, fairs and musical events. We visited Paul often and we hoped that he could stay there for ever.

In 1981, we were informed that the government had allocated funds to provide extra services for residents of special care homes. Paul was eligible and thought to be a good candidate for these services. We were asked if we would be included in this program. My husband was against Paul's taking part in this program. He felt that it was too late for any meaningful change to take place, too bothersome and a senseless waste of time and effort for such a severely handicapped individual. I, on the other hand, was enthused and interested to see programs developed for my child. My husband and I did agree that Paul should be included in this program on condition that we had the right to withdraw him if we felt the activities were inappropriate or harmful for him.

The triministry program, as it was called, was very rewarding for Paul and for us. The experienced, trained personnel of this program were eager to support any and all suggestions for Paul's program. They seemed optimistic that programming would benefit and change Paul. After several weeks, the behaviour therapist was able to determine that Paul had a range of thought processes and could adapt his behaviour to cope with new and different situations. Paul showed strong preferences for some people and was strongly attracted to male voices. Paul was very aware of routines and change in them.

Over the next three years, Paul again became a happy, active boy. He learned to feed himself. He went swimming weekly, and my mother was able to accompany him. He was taken out to activities in the community. He appeared more alert and involved in his environment. He began to respond immediately to his

name. He began to track people and objects accurately with his eyes. He began to tease his care givers. He actively involved others in his life by reaching out and grabbing them and often not letting them go without a real struggle.

The triministry program changed us as well. We were kept well informed about new programs and routines, and invited to open-house occasions. We knew whom to call if we had a concern. We were encouraged to visit at any time, and co-operative planning sessions for Paul were arranged to fit our convenience. Both of Paul's grandmas became actively involved. My mother went swimming weekly with the young people and became very attached to them. Both grandmas made afghans, quilts and picture books for the day centre.

In 1984, a residents' council was formed at Sunnydale and my husband and I participated. Later my husband served as chairman of this council. In 1985, a school program commenced at Sunnydale under the direction of the Durham Board of Education. Fifteen students attended in-house classes. This program in our opinion was inferior to the triministry program. The board neglected to inform any parent of its intent to educate their child. I found out that Paul was attending school, as he was no longer able to go swimming. He was in school from 9 o'clock till 3 o'clock. He could not go swimming. The board assessed these children without parental permission to do so and proceeded to program these children without parental consent. Clearly this was an infringement of my parental rights and an abuse of the law.

The teachers of these classes were inexperienced in educating this population. Supplies were virtually non-existent for months and these exceptional students did not receive services equal to other identified exceptional students in the community schools. The school staff refused to share pupil information, resources or expertise with other professionals. We, the parents, were strongly discouraged from being involved in a meaningful way with our child during school hours. Paul did enjoy his time in school but his life skills learning dramatically decreased.

These two diverse services to our son have clearly shown us how systems should function to increase opportunity for the individual and his family. During this phase of school board involvement in Paul's life, we at least had continued reliable home care for him. Worse was to follow. In 1986, we learned that all homes for special care were scheduled to close. We were devastated. Where was Paul to go? What was Paul's care to be?

Friends and counsellors from the Oshawa and Durham Association for Community Living and from the Ontario Association for Community Living encouraged my husband and I to visit several group homes and associate families to see if these options might be suitable for Paul. We soon realized that all agencies had long waiting lists and many were unable to provide the intensive care needed for Paul. We established the notion that a group home would likely be a good placement for Paul, but there was none available to us.

Again, with the support of association friends, we encouraged other parents to join with us to develop a policy

and program option for a non-profit organization to serve our own handicapped youngsters. Twenty-four-hour-a-day care would be provided, plus an in-house program of day activities would be arranged for each child. Twenty-one sets of parents worked for many months through hours of great discussions to form New Beginnings. This is an agency now operating two group homes and servicing eight young people here in Metro.

0940

I felt tremendous hope and optimism for this opportunity to again become meaningfully involved in my son's life. I expected Paul to live in a safe, secure home with quality care. I expected Paul to have meaningful day activities in the home to further develop his life skills. I expected Paul to go to school. I expected or at least hoped that Paul would have regular recreational outings.

Paul moved to ChesterLe home on 30 June 1989. Paul was admitted to school later that year and continues to daily attend a regular high school, Sir William Osler, in Scarborough. Thus far, Paul is the only such severely handicapped youngster educated by the Scarborough board in this manner.

Last summer, Paul attended a day camp for several weeks. The Scarborough parks and recreation department operated the program, which included a daily swimming session, group activities and weekly jaunts to community activities and events. We have been pleased to have Paul closer to home. We enjoy the opportunity to visit him regularly and to bring him home for day visits. We have started to go swimming with him regularly. We feel a closer bond to Paul now and we enjoy our times with him.

Changes have occurred for Paul. Some have been positive, but some have caused severe stress and anxiety for his parents and his siblings. Paul's care in the group home has been questionable. At times the home appears clean and tidy, at other times it is appallingly dirty and unkept. Recently Paul suffered a severe grand mal seizure. Paul's neurosurgeon determined that Paul had not been receiving his prescribed daily medication. This unnecessary trauma occurred because the staff are untrained in medical procedures and are inexperienced care workers. There is no legislated certification required to be a care worker. Thus far, Paul's in-house activity consists solely of watching TV. This staff has no programming vision or training.

I am personally frustrated, as Paul is now 21 and he will be demitted from school in June and there are no other educational options available for him. I am personally frustrated because I have been unable to locate a life skills program or a workplace setting for Paul in all of Metro.

I feel the policy to move residents from institutions back to the community is a great one. These youngsters can thrive and further develop in smaller homelike settings. These young people can become reinvolved with their families, neighbours and communities in meaningful ways.

As you can see, Paul's family relishes their involvement in his life. We want to see our dream for Paul become a reality, but this dream can only become a reality with strong, determined, creative people ready and willing to put their shoulder to the wheel. Changes have occurred

for Paul and his family and I am still enthused and stimulated by the great potential we have to make meaningful changes happen in the lives of our most vulnerable citizens.

Mr Zwerver: That is obviously one parent's story of the process that has led from a very segregated, institutional model to living in community, with the concerns that are very much theirs, as we all know. Part of our challenge now is how we deal with those kinds of ongoing concerns, even when someone lives in community and is supposedly part of community.

What I would like to do is to ask Maureen Brown, the executive director for the St Catharines association, to reflect the other side of that, which is really some of the critical issues involved in planning for individuals who are ready to move out of institutions, and from an agency administrator's perspective to reflect on some of those in a succinct fashion, and then we will open it up for some discussion.

Ms Brown: In listening to Mrs McPhail's presentation, some of the things came to mind that I think were raised by the members today. One of the biggest concerns for community administrators is the lack of consistency between the areas and the regions. If you have a good relationship with your area office, you usually can work around getting the necessary funds to bring the individual back to your community. Depending again on the region and the region perspective, some of my colleagues in other areas are not as lucky and have a difficult time trying to meet the community's needs.

Mr Beer: Excuse me, I am not clear. When you talk about the region, do you mean the regional government or the regional office of Comsoc.

Ms Brown: The regional offices of the Ministry of Community and Social Services. We would like regional government involved.

In the document there were supposed to be local planning groups, and many of the areas have formed local planning groups in order to incorporate the kinds of things we need to bring the individuals back to our communities. But these planning groups many times are not even resourced. It is done on an ad hoc basis. Some of the groups do not get support from their local ministry office. I happen to be fortunate and have a ministry office that is very supportive, but some of my colleagues complain about the fact that they do not feel their needs are being listened to.

The other area we are very concerned about is the lack of support in the community associations' infrastructure. Most associations have tripled, quadrupled in size since the multi-year plan has taken place, and many of us are still operating on the same models we operated on five, six, seven years ago, yet we have a lot of staff, we have union, we have parents who need our support, and we do not have the infrastructure in place to run basically a business. I think these have to be looked at.

We are concerned about how the dollars are accessed. Many times now when an individual is identified to return to the community, such as St. Catharines, where I live, v

have to prepare a proposal for the ministry that would encompass an actual plan, such as a group home. So if I have two or three people of similar needs or likes then I would put in a group home plan for those people and attach dollars to some day program or other supports those individuals need. We seem to forget some of the other supports. Many of these individuals come with behavioural needs; they need school support; they have medical and physical needs. I think it is very important that we try to look at the individual; if he does not actually fit into something we currently have, let's try to be creative. But we are locked into the system now and I think that is sometimes not very good for the people. That is one of the things we get discouraged about, very much so.

Certainly the wages are improving, and certainly some of the things Mrs McPhail mentioned about the untrained staff is improving because of the fact that we are able to pay a little more and we are able to keep consistency. In the cities like Metro it is probably a lot more difficult than in a community like St Catharines or the Niagara region. But I do think that is improving and we thank you for that. We have a ways to go. Of course, our staff needs more training and support through the Ministry of Colleges and Universities to teach our people how to look after these high-need individuals returning.

Those are some of the bullet points for myself as an administrator. Again, other areas experience different things, but I would be pleased to answer any direct questions at this time.

Mr Owens: First, I would like to thank Mrs McPhail for her very frank description of the problems she has had in dealing with her son Paul and the system as it exists today and yesteryear, which is not all that far away.

I would like to talk about some of the supports that are in place for families and perhaps where you see that lacking. You describe a fairly horrendous process at the beginning of your time with Paul, when he was essentially deemed only prepared for palliative care as opposed to developmental care. What kind of supports are in place to deal with the kind of intrafamily tensions that kind of situation can bring on? You mentioned a disagreement between yourself and your partner about which direction that treatment could take, and I am sure it was not as polite and succinct as you described it today. I am concerned about that, about the kind of services that are out there to help support families through decisions like that.

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In the later part of your presentation you talked about the current group home situation and your concerns over staff training. I wonder if you or your group are prepared to make the kind of recommendations of what you see as being needed to promote staff training to bring them up to the level of competence you feel they should be reaching in standards of practice. In speaking with staff people who are currently working in these group homes, I know they have your concerns. It is not just the parents who are concerned about the level of service that is being provided; the staff is deeply concerned about whether the home is cleaned or whether your son or the many other children

who are in these homes are being provided with a stimulating and challenging program.

Mrs McPhail: I do not know what the support services are today for parents going through a crisis. When we were first advised to place Paul, the doctor made the decision, phoned Surrey Place Centre, which was the regional placement centre for all the children in the Ontario region, and they came out. They said to us, "We think your child should go to an institution." When I said, "I need time to think about it," they were quite annoyed, because they were the professionals, they knew what was best for my child. I do not know whether that has changed.

Shortly after that, the Scarborough Association for Community Living invited me to some meetings so that I could meet other parents who were dealing with handicapped children in the home, but their needs were different from mine. I did not meet at any time another parent who was placing his child in an institution. Until we ourselves decided that our option was to meet with parents to discuss bringing our child from an institution back to the community, I had not met another parent in Sunnydale Nursing Home with the same needs and concerns I had. I am not sure if that is different now.

Mr Zwerver: In fact, the next two presenters are going to talk about the whole area of family support and what is happening currently across the province, from both a parent perspective and an agency perspective. That might help answer the other part of your question.

Mrs McPhail: For the staff training, I would like to see some legislation in place. I am a teacher by career and I cannot teach in the public school unless I have good quality certification. I am not sure why care workers who are looking after the most vulnerable citizens do not have to have some kind of certification, because there certainly is some essential training that must take place for them to work in these group homes.

Mr Jackson: Ms Brown, maybe you could share with the group the last two homes you were able to open, or three—how many homes have you opened in the most recent—

Ms Brown: Four.

Mr Jackson: What was the ratio of community based to institutional based?

Ms Brown: Two community and 20 facility.

Mr Jackson: I suggested to the minister yesterday that in the original document of the multi-year plan there was the matching approach, that we would assist those families with children in the community and those with children in institutions and we would go on a matching program, yet I am tracking more specifically the fact that it has become an exclusively institutional-based transfer. Can you share with this committee further insights in this area? In my view, it is a deviation from the multi-year plan. I am also concerned that it has become a policy of the government and, if not checked, will continue to be considered the norm once we are past these hearings. I have one other question after that.

Ms Brown: As far as the matching is concerned, for the community agency I did not think that was in place any more. About three to four years ago we were told that really was no longer valid, that the dollars community agencies would get for development would be attached to individuals currently living in schedule 1 facilities and nursing homes throughout the province. When an individual is identified, such as in the homes we were, whose home might have been in the Niagara region or the St Catharines area, we go and meet these individuals and try to match them with individuals of similar needs so that the home can be fairly supported by like staff. We can squeeze in the odd community individual.

I agree that it is a crisis for us. In St Catharines alone, I have a waiting list of 54 families who want their sons or daughters placed yesterday. They are saying: "You're bringing back these people from the institutions. We know their home community is St Catharines and we applaud you for it. However, that doesn't help me. I'm 75 years old and what am I going to do about Bill or Joe?" I say, "I realize that and I am trying to do my best."

It is frustrating for all local administrators, the fact that we are not able to support the families who have for whatever reason been able to keep their sons or daughters at home. We do, though, firmly support deinstitutionalization, whether it be the citizens of the world or people who are coming back. But you are right that in the homes we have opened up, there have only been two community people served out of the 20.

Mr Jackson: That is an experience I have heard from other groups as well.

I have another quick question. It has to do with the bump funding, which concerns me. The first point—we did not have time to ask the minister—is that we have not received our transfer payments for transfer payment agencies in this province, of which you are one. It has never in the history of this province been this late. Having said that, bump funding was delayed several months from the time it was first announced. We now have received the bump funding and I am hearing from the associations that it only partially addresses pay equity, as well as some other issues, but it is not really moving the salary grid to the extent we had hoped. Could you tell us what your experience is in your association? We will certainly get an opportunity to hear from Harry with respect to his global view, but I would like to take this occasion to ask how it has affected your agency.

Ms Brown: It has been really good. Yes, it was late, but with the election and things, we understood that. Our staff really did not, but we just kept holding them off. Basically, it is retroactive until 1 September, so no one has any dollars yet. We do not have the dollars; I just have a note saying how much I got, so I am just hoping it is going to come. But it has made some difference to the staff. Yes, they still are being paid less than their counterparts at schedule 1s. I happen to be in an area, though, where there is not a neighbouring schedule 1 facility, so it is not as apparent as for someone who is in the London area, say, where they are actually neighbouring right by someone.

Our competition is mostly with school boards and things like that, community colleges, which can pay more. But it has made a difference and I am hoping it will continue to make a difference to try to attract the kind of individual Mrs McPhail is alluding to, who can work in our homes, who has the expertise and experience needed to look after these vulnerable people.

Mr Jackson: I wish we had more time. Thank you.

Mr Beer: I have a couple of areas I would like to talk about, but are we going to be coming back to the funding? Is there another place where you would, in the global sense—because I appreciate Cam's question and I think it is important that we see how it is working locally and globally. Were we going to be coming back to that?

Mr Zwerver: I was going to take an opportunity near the end to pick up on that issue, but we can do it here as well.

Mr Beer: Fine, because I want to take advantage of having a parent here as well as people who come from individual group homes or administrative settings, to get a sense of what it is you go through; then that will help us as we move to the global.

Mrs McPhail, I found your voyage of discovery, if I can put it that way, extremely well done in terms of the humanizing of the process and the different kind of points along the way where, as a parent, with the expectations any parent has for any child—we all know all of our kids have varying levels of ability; it is just that here we are talking about some who are perhaps more obvious and more in need of assistance.

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I was trying to get a sense of some of those critical places where as a committee we might be able to help in moving the system forward or making that system, I think as you and others have said this morning, more responsive to individual needs. I want to make sure that I have understood some of the things you have said.

I take it that you see the concept of the group home as being essential in this framework, but that group home—your comments about New Beginnings and some of the positives and some of the negatives there, clearly that the requirement of appropriate support, whether in terms of the kind of training the people who are working there have, the funding that is available and just the setting, the sense of home and community.

With that program, in terms of the involvement of parents—and I think this is one of the themes frankly last week we were dealing with in children's mental health issues and in a lot of these areas we hear that commiseration, as a parent, feeling blocked at times by the system. I think you said at one point you had to be obstinate and quite frankly I find that in a lot of these areas that is what takes. I am sure that is not the way you wanted to necessarily do it, but it is the only way that you found that you could get through.

How do you see the parents' role as we go forward? What kinds of things might we be saying that will strengthen the involvement of the parent in the development of the services, of group homes, of other kinds of

settings that perhaps we ought to have? How do you feel right now about parental involvement and what are the things that need to be done so that, in your view, you would have a much greater say in what is going on?

Mrs McPhail: As parents, I think we should have the full support and encouragement to be involved in every area of our child's life. It has been difficult for us since Paul moved to the group home because it was a group of parents that developed this idea. Now I think we are kind of looked on as, well, we are not professionals so we really do not understand the system still and we are too emotionally involved so we really do not know what is right for our child, which I do not agree with.

I still have expectations for this child, as much as for any other three children. I feel that I should be totally involved in this planning for my child, an indication of where he is going, what support services I would like him to have and what are the essential services in the community. I think parents have a lot of creative ideas to offer here.

Mr Beer: Where does the professional come in in terms of your own setup then? How do you, as the parents, relate to the professionals and how does that work, in your view?

Mrs McPhail: I would like to see a professional who is experienced, well-trained and knowledgeable about services for these children and has a visionary view of it to help us develop these ideas more fully. I see that as a very important part. I see it as an important part for the staff to be involved with parents too and get to be like a small family so that they know and understand our values and our ideas as well as we would understand their values and their ideas.

I really see it as a visionary person leading a group probably that has some new ideas and different ideas that he has seen at work in other areas who can share those with us.

Mr Malkowski: I have been very impressed with the presentation in terms of explaining your experiences, what you have had to go through as your child has grown up and the struggles you have had to endure.

I am wondering, at the very beginning, at the time, did you receive any parental support relating to the grieving process as well? I am wondering if you had opportunities to meet with consumer groups to get them to share their experiences with you in terms of what they had to endure through the system.

I can see from what you are saying that most professionals will advise parents on what to do, but often the consumer groups or advocate groups are not involved in terms of offering parents their perspective on their experience. I was just wondering what has been your experience in terms of consumer involvement.

Mrs McPhail: I have not received much support from community groups or individual citizens, perhaps because our experience is very unique. I have received support from friends that we have made over the years in the associations, personal friends that I have made through my school years. I actually myself have gone for counselling

sessions. The counsellor said to me: "I do not understand this area. We do not have people going through this. I cannot advise you. I can only tell you what has worked in a general sense for other people."

This is a chronic grief system. It is not something that stops. There is no end to the story yet, so I cannot get over the grieving process. I have to continue through and struggle with it to try to make the dream still a reality for us. This is a difficult situation to deal with personally. We have that emotional issue to contend with continually while trying to contend with the business aspect of getting on with our child's life and our lives.

Mr Malkowski: Do you feel it is important for parents to receive emotional support from the group at the very beginning, as soon as the child is diagnosed, as well as getting the consumer perspective as soon as the child is diagnosed? Do you feel that those two issues are important?

Mrs McPhail: Yes, very much so.

Mr Jackson: The only reason I ask this is because for years people have asked me the question, "Where do I get help, Cam?" When I was a school trustee it was through that vehicle, and then here at the Legislature, but I find an overwhelming number of people who are not members of the local association. They vary in terms of having their own healing circles. They vary in terms of having their own in-house professional counselling or group counselling. At what point did you join an association and what was your experience?

I know that is a delicate question in one aspect, but I am sorry, I am a strong advocate of joining associations and building those healing circles within them. I wonder at what point you joined, and I think that is what Mr Malkowski is getting at. What advice could we give that might focus in that area?

Mrs McPhail: When it was first suggested that we would have to place my child, as I say, we were involved with the local association. I felt the people there really tried hard to involve us, to give us some support, but because their situation was so different, they were not having to deal with placing a child in an institution, I could not strongly relate to them.

So we did not become involved with the local association again then for many, many years, not until I knew my child was coming back to Scarborough. Then I became reinvolved and am a member of our local association.

I think they are very supportive people. They are terrific people. But because they still have not had the same, similar experience as we have, they have not been able to support us emotionally. The people who are now supporting us are the other parents in our group home.

Mr Jackson: That was my point.

Mrs McLeod: I was just wanting to comment before asking a question that I sometimes think if we go back, and your experience goes back such a long period of time, we do not always have the knowledge of what was in place then and how much that in fact has changed. You really were pioneering towards a very different kind of

environment for your son. We have come a long way, although there are still problems we have to identify.

If I could come specifically to the question that I think Mr Jackson was beginning to address with his first question, that is the issue of support services that are there for people currently in the community alongside the supports needed for the deinstitutionalization. I was a member of the cabinet committee when the deinstitutionalization plans were being further considered. I know that there was a very strong recognition at that time that there were waiting lists of people in the community needing support services and that those had to be addressed. They could not be put on hold while the deinstitutionalization plans went forward.

I guess one of the concerns that I have certainly continued to have as I talk to people in my own riding is whether or not somehow that commitment did not become translated into the services that were actually provided in the community, whether or not that sense of commitment had not been conveyed, whether or not the expectation that the community needs of people would be met or whether it was funding that had not kept pace, I am not sure, but I wonder if you could just comment on whether or not there was even that recognition that the support services had to be provided for people in the community now.

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Mr Zwerver: This might actually be a good time to move to our next two presenters, because their whole focus is on the issue of family support and support in community. If they can take a few minutes to outline that, it may make it easier to kind of get a focus on where some of this needs to go.

The Vice-Chair: I do have two other members who wish to ask questions, perhaps on the previous set of discussions. We should probably proceed with those and then move on to this other area. Is that okay?

Mr Zwerver: That is fine.

Mr Johnson: It is unfortunate that often we cannot ask these questions more timely. With regard to the group homes, I was wondering who owns them, what it costs to fund them and who pays for these costs.

Ms Brown: It depends who owns them. In our association, we own the houses. There have not been any capital dollars from the ministry in the last few years, so our association has fund-raised for the down payment and then the principal and interest is debt-retired through the operating budget that you receive in order to fund that home.

The cost: Again it would depend on your area, what you would have to buy for a home. The homes are like homes like you or I would buy. Basically, the operating budgets are dependent again—and this goes back to having to take the individuals from the institution and not bringing in community people. An individual from an institution may come with \$50,000 or \$60,000 annualized. You put four or five people into a home, you staff it, you buy food, you buy clothes, so you end up with an operating budget somewhere around \$200,000 to \$300,000, less their family benefits allowance.

Mr J. Wilson: I just have a short question for Mrs McPhail. In the group home setting, when there were problems with Paul receiving his medication properly and on time, was that more a function of improper service or not timely service, or would those care givers have required sort of paramedical training?

Mrs McPhail: I think they require more medical training. I do not think they understood the importance of his needing this medication daily and at specific times of the day.

Mr J. Wilson: I think that is important when we look at the training of care givers in the group homes in the sense that there would be a real cost factor there if we were to provide paramedical training, and that is why it is important. But in your case it would have helped a great deal.

The Vice-Chair: Let's go on to the next presenters.

Mr Zwerver: The next two presenters will be Doug Cartan, who is the executive director for the Brockville Association for Community Living, and Michelle Friesen, who is a parent from Windsor. They are going to take a few minutes to talk about what is presently happening in the province in the whole area of family support and community development. I think that will get at some of the questions hopefully that Mrs McLeod was asking and other issues that I know some of you would like to address.

Mr Cartan: Thank you very much for the opportunity to speak with you today. This aspect is extremely important to us and I want to give a brief introduction to it before passing it on to Michelle Friesen.

I also want to say that no evaluation of the service mandate for individuals, or in fact the multi-year, plan can be complete without an examination of what has been put in place of the institutional options that people had to choose at one time. If we have any expertise to offer—and I hesitate to use that word, but between Michelle and myself we have significant knowledge of some of the flagship programs that the government has put in place to support families and hopefully to provide other kinds of options so we have an extreme amount of knowledge on that between the two of us.

One of the programs we wish to talk about today is called the special services at home program. It is mentioned again and again as a flagship program replicating the principles of the multi-year plan, mentioned when the plan was initiated in 1987 and mentioned in the most recent speech by the current minister. We want to talk more about how that is or is not meeting the test of the support that need to be put in place for families, given that we have curtailed the institutional options for children and other people, which we applaud. It is those kinds of question that we hope we can get into even more personally in dialogue process.

At this time I wish to turn it over to Michelle Friesen who is a parent from the Windsor area, to talk a little more about her experience of supports at home and with her family.

Mrs Friesen: I will just tell you a little bit about myself before we get going so you kind of know from where

am coming. I am a mother and I have four children, like Eva, from ages 3 to 13 years old. I brought pictures too, but mine are big enough to hold up. As I am holding them, I will just tell you a little bit. One of the things I want to talk about is the idea that all of us are really busy within families. These are my two oldest. They are 12 and 13 years old; and my two youngest, 9 and 3. David, Nicole, Lisa and Matthew. I guess I am here because of Lisa. This is my daughter Lisa, who is 9 years old.

My family does keep me very busy, between the two pre-teens and their rebellion and all of their after-school activities and running around with their friends; between my daughter who is 9 and her wanting to be with her friends and enjoying their time together and all of the things we do with her at home that she enjoys, and between my 3-year old, of course, who tries to get a little time in there some of the time.

I would like to tell you a little bit more about my daughter Lisa. As you can see, she has beautiful long brown hair and brown eyes. She loves being with her friends. She enjoys going to school, smiles widely. She is one of the tallest kids in her class and that was discovered by laying her on the floor and having the tallest kid in the class lay next to her. She has a beautiful smile and a contagious laugh, and like most 9-year-olds, as I said before, loves being around other children. She is at the same school as my other two children in our community. I live in a rural community in Essex county outside of Windsor.

In the past, I guess over the last 9 or 10 years that we have had Lisa, there have been people who would describe her to you differently from what I have just described, and

I am going to sort of go over some of the things that we have been told. To the local association, she was once a client. As a client, she has been part of a case load. As part of various case loads, she has needed all kinds of various therapy—physiotherapy because she has cerebral palsy, visual stimulation because she is cortically blind, intellectual stimulation because she is severely developmentally delayed. So we have a severely developmentally delayed child with a microcephalic brain who has cerebral palsy, seizure disorders, she is visually impaired and she cannot do anything for herself.

Yet my first description of her as being a happy child who enjoys her friends, I think, is more welcoming, and I start this way by saying to begin with, when we label people, we set up barriers. If I were not to have introduced my daughter to you the first way, I think you would have had a harder time sort of even thinking about getting to know her.

The children in her class and the kids in our community who come into our home do not know what any of those words mean, but they know exactly what she needs, and nobody has ever given them that list to describe her. They know that she needs somebody to be her eyes and that she needs somebody to be her hands and that she needs wheels to be her legs and they know what she likes to eat, what she likes to do and they know how to communicate with her even though she cannot speak and they know how close to hold up something so that she might

see it, and they never got a diagnostic list of labels to tell them that.

One of the things that happens as our kids enter the system as infants with all of these labels is that professionals start to take pieces of them. The physiotherapist gives you this program and you are supposed to do that, and somebody else says, "You have to do this to stimulate the eyes," and somebody else gives you a feeding program, "It is taking an hour at a time to feed your child and this is the way you are supposed to do it." Pretty soon you have tons of agencies and professionals in your life telling you, each of them, what you are supposed to be doing, and nobody is looking at, "Here is a young mother who has a child with high needs and two other toddlers in the home, and how the heck is anybody supposed to get any of this done anyway, because it is totally impossible."

Nobody ever looked in the earlier years at the family, the unit of the family and what was there and, "What does the whole family need, what does the child need in relation to the family and what could we do to support that?" Because it was difficult and we were not coping, the first advice we would get was, "Why don't you take some relief at the neighbouring institution?" That was all there was at the time. My daughter was 16 months old. When we went to the institution to visit, one of the things that really struck me was that that particular institution was mainly filled with adults. There was not a crib in the place. There were hardly any children, and reams of people who had to be helped to eat. I said, "How long do they get to eat?" "A few minutes each." My daughter needs an hour and a half or she will starve.

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Of course we said no way could we manage that, but I have to say that had not a program come into place within the next six or seven months we could not have managed any longer. We had reached the breaking point, but special services at home was developed in the meantime and people were plugged into our home to help with our daughter.

That was not the be-all and the end-all for us, however, because as the years progressed it was a constant battle and struggle to convince the professionals in the community that it was something that needed to be ongoing, that it was something we might have, in our case, needed a lot of. It was a constant re-educating of the people in our community around that. They were always looking at the rules and regulations of what the program or the agencies wanted to do.

That is the second thing I want to come to, is that it is a barrier to families and support to families. The first one would be the labels and the programs and not looking at the family as a whole and holding that family in high esteem. The second would be rules, guidelines, agency, association, whatever kinds of stringencies that are put on families.

An example I am going to give of that for us was that we needed relief for our daughter. Later, as years went on, there was a relief bed in a neighbouring group home. However, we did need a lot of in-home help as well. One of the conditions for us getting help in the home is that we would use the group home a certain portion of the time for

relief. That ended up being quite a headache, because we had to train staff. Lisa would come home dehydrated. They could not feed her, they could not give her a drink, and on and on and on. It got to the point where we were raising such a stink—and I had many of the same labels that I think Eva does—that they said, “Fine, we’re going to give your child somebody to take care of her for 12 hours a day in the group home,” I thought, “Why can’t I have somebody at home 12 hours a day?” but that was not the way it operated.

I am only saying this to say this still goes on. Because the services and the systems are in place to do things in a certain manner, families who are able to identify what they need and want are always caught in the middle; they have this over here, but these are the rules and we have to do it this way.

The third thing I would call a barrier is the way professionals listen to families. They do not always listen to families. The people who are running some of these systems and the people who are out there are not hearing what families are saying. The families are saying: “This would work for me. All I need is an individual plan and a little bit of money and somebody to support my ideas and help me in my own community, then a lot more could be accomplished.” I firmly believe that a lot more energy has to go into the community people live in, so that the people at the library and the park and that kind of thing can get used to our children. That means if people want to keep them in the community, individual life dollars have to stay with those families. That means special services at home.

The families I have been involved with range in age from parents of infants to adults. The parents are saying that this is what is working for them, this is what is empowering them and this is what is helping their families, so that we are living by our own rules and not by the games of so many agency- or association-set-up programs. What happens when all of the resources are put in the pots of agencies and services? As families, you become dependent upon those agencies and services, because that is where the resources are and you have to follow their rules. I think it is dangerous for us as a society, as a province, to continue to make people dependent. Families want control, as Eva said. Families want to be empowered, and oftentimes they do need somebody who will listen to what it is they want, support them to get the resources and, if that is what they desire, help them to operationalize it. They need choices.

Harry asked me to go quickly and to only take five minutes, so I think I might be leaving a couple of things out.

I want to say that I am involved with the Windsor-Essex multi-year planning committee as a consumer. I have been on the committee for a couple of years. I think there has been a lot of growth in terms of that particular planning committee looking forward, and a vision and the ideas are there. However, I have the same concern that it appears that that planning body or that community is also strangleheld because of the systems that were in, when comments come up like, “We just have to wait and let it evolve and it will change.”

More and more families push for this, and I am saying we are out of time. There are people now who do not want to get into the stream of the existing systems and agencies. They want a different approach. They want the resources to put in place what they need for their kids. They want a co-ordinator or somebody who will listen to them. In our association right now people are so bogged down with budgets and staffing and meetings and doing a good job with all the other stuff they have to do that they do not have time to do that, there is not the staff to do that. There are a lot of parents coming together in Windsor and they are saying the same things: “Why can’t we phone one place? Why do we have to phone all these different agencies to get what we need? Why can’t we phone one person who can help us and why can’t we put in our own plans? The program is very successful, but it has to go further.

Ms Stone: I would like to point out, too, that this is a very articulate parent. She is the kind of parent who makes things happen for her child. But what of those who have trouble with language and do not have the education to be able to go forward with confidence asking for what they need? Those parents are left. I think both of us would agree that some attention has to be paid to the universality of this program being available to everyone, not to those who are more articulate or are able to express the needs of their children better, but available to anyone who needs it regardless of handicap of the child.

Mrs Friesen: I think also that if some parents do not come forward and say to the professionals that they need these same things—they do not always feel confident to do that—there is the mistaken assumption that everything is okay. Yet parent to parent, over and over again, the same thing comes up. Some of those parents just are not comfortable with coming forward, but they say it to each other and they say it to me and they say that is what they really need.

The Acting Chair (Mr Miclash): Would you be comfortable with some questions?

Mrs Friesen: Doug, do you have a wrapup?

Mr Cartan: I think questions will be more appropriate at this time.

Mr Owens: Once again we have, direct from the source, comments that I always find more helpful in crystallizing issues, especially situations like this, rather than just the “professionals.”

The issue I would like to address is twofold. One, respite care and the other is creativity in the provision of services. In terms of attacking waiting lists, I need to go some kind of direction on the level of respite care that might be needed within the community. It is my understanding that some facilities have only one bed available for respite care and that the need far exceeds that one bed per weekend. I wonder if you could tell the committee about your experiences in trying to obtain respite care and perhaps some of the experiences of some of your fellow parent contacts.

The second question is on creativity in the provision of services. I am quite interested in hearing more about this in that it seems that once we have one model set up

provide services we stick with that model for better or for worse. I wonder if you could make some recommendations to this committee on how you feel the government could be more creative and perhaps even more proactive in providing services such as care at home and many of the other services that you find both useful and also required for your child.

1030

Mrs Friesen: I will start with the respite, and I can tie a little special services into that, too. I served on an inter-agency committee for a year or so in our community that was looking at respite care needs of individuals with higher need. At that time, the only opportunity for respite was in a couple of group homes in the community where there were beds set aside for that. What a lot of families were finding was that the model was very curtailing, very difficult, because you had to quickly get on the phone to get your bed and it might not be the weekend you needed it and you might have to go without that month.

The other side of it was that it was a model that really was not working for all kids, because you have so many staff shifting and they do not know your kid very well. An example is that a daughter of a friend of mine went in and they fed her something she was allergic to and she was rushed to the hospital and almost died. It is a difficult model to provide respite with.

In our community we worked for the number of years it took to finally develop something that was family-centered. It has grown from serving no families in March of last year to serving 50 families now and matching them with other families in the community; where many people are receiving their respite care in our community is that a co-ordinator has been hired to search a family in the community near the family, match them up. They are paid for service: I call it an honorarium, because for what they are doing it is not a lot. It has worked really successfully. It is also serving the most families, more than the associations are with their beds, because I think especially for a lot of younger families coming up it is seen as something they can feel comfortable using; people kind of hold back until their child gets a little older before they use a group home.

The way it ties into special services is that if families were to have an individual budget for their needs, if the family were to say, "I need so much help to do this and this at home, but I also need some respite care," and that became part of their individual family budget, it can be done with special services. A co-ordinator in the community can find a family and they can get some of the special services dollars to do family respite.

Ms Stone: I think respite, as with special services at home, needs to be flexible. I have a 20-year-old son who has a developmental handicap. He operates normally—I mean, to look at him he does not look visibly handicapped—but to find a babysitter for somebody who is 20 years old is not easy. In fact, it is virtually impossible; the kind of money you have to pay to get people to do it is very difficult. He operates best in his home environment, so to have someone come to us is much more easily handled by us and by him and probably by that companion

person than if he went to someone else's house. That upsets his routine and is very difficult. So in my case that would be a better scenario.

In some cases having the child transported somewhere else works better. Having another family in place can sometimes work better for some families. But I think it is really important to have that flexibility and to have a variety of choices so that it works best for the person with the handicap. It also works best for the family and for the support mechanism that is in place. I believe that is true of special services at home. It cannot be tailored. You cannot set up a rigid structure that says, "This is the way it must be." The reason it works so well and is so much in demand is because it looks at the family. If I only need three hours a week, that is what I ask for and that is what I get. If I need 15 hours a week, then that is what I ask for. The makeup of that 15 hours is left strictly to the family, and that is really important.

Mrs Friesen: I probably made it sound like all of those 50 families receiving relief were doing it through another family. I should not have, because in some cases people are coming in.

Mr Jackson: I am glad you started to further refine this notion of respite and home care, because I think we need to clarify for the committee that this is a multiple delivery system and it has evolved over a number of years.

Mrs Friesen, you talked about Lisa's experience when she was nearly two, which would be seven years ago. Am I to understand that you did not have home care services for your local—it was not one of the pilot projects?

Mrs Friesen: We were not aware of special services at home. We started asking for it when she was about 20 months old. It took five months to get into place. She was almost two when we started receiving help.

Mr Jackson: Maybe you are not qualified to get into this area, but perhaps at some point we will come back to this issue, because I have some concerns about how that system works in terms of it being an envelope; I have had experiences with families who fought to have their number of hours reduced while other families could not get access to the envelope. There are serious problems with the manner in which we administer that. I wanted to ask you to explain more clearly the difference between respite, which is in a sense moving out to another location, and then special services at home brought in and the kind of support that gives. Perhaps it has now been clarified a little better.

Mr Zwerver: Maybe Doug Cartan can try to answer that and add a broader context, both the history of the program and how that has come together as well as some of the realities of how that is being administered at this stage.

Mr Jackson: One other point, because I will probably lose the floor unless I get the question on. I want to thank both Mrs Friesen and Mrs McPhail, but I have to be very careful how I say this: I am very impressed with your presentation, but you are certainly not totally representative of the kind of parents we have out there. In my 17 years of doing direct association work, I have had cases—first, we keep talking about family, and we must at some

point underscore that we have a lot of mother-led, single-parent families, that there is a high incidence of this. We do not wish to discuss why that is, but there is. I have been called by doctors at 11:30 at night saying, "I am admitting Mrs So-and-So, who has had a nervous breakdown, and we are scrambling to find someone for the child." I think it is important that we get on the record at some point—the word "desperate" comes to mind in several cases I have dealt with in my community and how terrible the support system is at that moment of crisis.

I think we serve the committee well if we allow that to be put in perspective—not to take away from your presentation, which was child-focused. You are exceptional parents by virtue of your presentation today. We have a lot of parents who have nothing but their love to give their kids, and there are some differences out there. Those are the two questions.

Mrs Friesen: Would it be okay if I respond to that, or is there going to be a question at the end?

Mr Jackson: Those are my questions before I got cut off; I have left two hanging out there.

The Vice-Chair: Was there a question there, Mr Jackson?

Mr Jackson: I wanted them to perhaps expand the description of parents. I sense those are the only two parents we will be hearing from on the association today.

Ms Stone: Well, me.

Mr Jackson: Three. I am sorry. You wear three hats, actually.

Mrs Friesen: I get that kind of comment quite frequently: "You are different from other parents. You hang tough. You have it together. It may be easier for you." At the risk of being vulnerable to a pile of people I do not know—Charles can attest to this; he has heard me speak before—there have been times that I have been very close over the edge, totally exhausted. In fact, I slept two hours last night and have not slept for three weeks. You get a little adrenalin when you do some of these things. It is very tough at home when the load gets heavy and there is not the extra support. I say that to you because I am not that different from any other parents. The other parents I meet, when we share one to one, may not be able to speak it out, but we have more in common than we have differences. I can appreciate what you are saying about single mothers, because it would certainly be doubly hard. We have had our personal crises and we have had our moments, but I am thankful that we are in a community and that there are some people I can call on, because she has been in community and been supported to be in community.

Mr Cartan: I wonder if I could just take a little further the question you have just mentioned now, as well as previous to this. People have asked whether the multi-year plan is meeting the benchmark or the standards that have been set. That is one of the reasons for looking at this. Our presentation focuses, on pages 15 and 16, on Challenges and Opportunities, which is what we really want to talk about. If you look at those pages, you begin to look at the flagship initiative for providing other kinds of service and

support to individuals so that institutionalization is not needed. That is what we are talking about here: Is the cup half empty or half full? That is part of the presentation here.

To put it in a different context from Michelle's, because I am not a parent but I help to implement and deliver this program to people, I want to say that, first of all in terms of describing relief and support, there are two types of relief and support in this province. One is out of home. You go somewhere for a weekend, a week, a day—time—somewhere to a home or to a bed somewhere.

1040

The other type of relief and support, which is more preferred by families by and large, is in-home support paid through a program called special services at home, which is by and large administered through the area office of the government. We are just concluding the eighth year of that program, so one could say it is an eight-year-long study of what families need. It was a needs study here. We have many lessons from this eight-year-long needs study which we can now present to you which we feel are not yet being taken seriously, and that is the issue we want to raise today.

The eight-year-long needs study has shown us that while the program was set up in order to have a quick in and out to a family—see what is wrong, do something and back out, a six-month agreement and then the six months are over and you are back out—the prime use of the program for families is that once you use it, you will probably want it again because chances are the handicap does not go away, chances are the family stress does not go away. So the intention of the program does not match its current use.

The good news is that people of the day, the eight years, allowed things to be flexible. They did not say, "Six months; get out; you can't use it ever again." People realized: "Maybe we should just go with what families are asking us. Let's just see what is happening." So after eight years, we find the majority, as much as 75% to 80% of the families who use it once use it twice, three times, four times, since 1982, like Michelle. That is number one.

However, the policy surrounding the program, the policy surrounding the main flagship initiative to prevent institutionalization is still last resort once you have tried everything else. It is not a primary home support option. As a result, many things fall out from that. Number one we do not commit serious dollars to it. Number two, we do not have a policy of multi-year funding to a family, so a family has to get nervous and frightened every 6 and 12 months, and that is happening now in the province.

We do not treat the support family's needs the same way as we support service structures like group home when a family gives up a child to a group home or to an institution. We indicated to you earlier that there is a wage discrepancy between institutions and community staff. The same discrepancy exists between community staff and people doing home support. We are now creating a third system. The third system is a home support system and has an equal if not greater gap in the wages paid those people. So in other words, if you want to look at the value of someone in our society and you apportion that value to the wages that person gets, which is one way of looking

value in our society, the most valued workers are if you give away your son or daughter to an institution; next, if you are in a group home; and the least valued workers are the workers who support families to have their kids, sons and daughters, at home.

So it is an issue of the amounts of resources we are committing to it, but it is also a policy issue which can be done, it can be looked at, multi-year funding for families. Group homes do not have to sweat whether they are funded on 1 family, families do. My question is, why does that have to happen?

The second thing we want to talk about, and it is an issue for us and I deliver this program to 60 families; we hire a lot of people in delivering this, besides the wage, but it is becoming another women's ghetto of work. Not only do we have statistical data in our society to indicate that women still do a lot of child-rearing in our society, women are the people we are employing in our agency to deliver this program. We are averaging somewhere around \$7 an hour to do something that we have now set other minimum standards, because of wage compensation adjustment, for community workers, not to mention institution workers, which for me is like nirvana in terms of being able to retain and control people.

So I want to indicate to you that, number one, the program is good. It is a good direction and we all applaud this direction; it just ain't taken that seriously in terms of the option for institutions.

The other thing I want to say in terms of page 16 on the program called special services at home, again, as the flagship it talked about adults. What happens to the 75-year-old family with a 50-year-old son or daughter still living at home and they do not want an institutional option or a group home option? After eight years of the program, after nearly four years of the multi-year plan, that family can still not access the dollars. The cup is less than half empty in terms of adults. It is probably half empty in terms of kids and families because there are some things going on, but in terms of adults it is woefully inadequate at this time. My agency has just had applications for adults, a 65-year-old single mother with her 33-year-old daughter, turned down for the program that was just expanded to serve adults.

A final point I want to make about the program, putting it in a systematic context, is that there is emerging in the province a pent-up demand, which has been alluded to by the Ministry of Community and Social Services for some years now, of adults who need support. Rather than being resolved or met, that pent-up demand is simply growing and the expansion to services in the community has not happened.

Special services at home is the one program which replicates all of the principles in the multi-year plan. It is the only one besides orders in council. It is the only one that replicates all of the principles of the multi-year plan and we have yet to take it really seriously as an option.

The Vice-Chair: Perhaps at this time I can point out that we have less than half of the time remaining that was allotted originally. As far as this section goes I have a great

number of members on the list, but you have three more presentations to make, if I am correct.

Mr Zwerver: Essentially two more presentations; one on employment and another one on advocacy, essentially.

The Vice-Chair: All right. We can go on for at least another 10 or 15 minutes and then split the last hour between the other two presentations. Is that a good way to finish this?

Mr Zwerver: This is a pretty critical issue which is core to so much and reflecting on the policy as it has been developed and as it reflects the principles of the multi-year plan, and I would suggest to you, as a committee, that it is really the core issue to where we need to go.

The Vice-Chair: I just wanted to try to guide you in terms of time.

Mr Zwerver: If we take the next 15 minutes to deal with questions, we could probably pick up our starters in the other areas involved.

The Vice-Chair: That is fine. Very good.

Mr Beer: It is nice to see you on. I am very glad to hear about the respite program. It is nice sometimes that something that gets started works. We talk about this and other areas that are in the broad social service field. We know that we are trying to do things to move the yardsticks and yet there are still tremendous problems and issues.

What I would like to focus on here from all three of your experiences is, I do not think there was a program I learned about in the short time that I was in the Ministry of Community and Social Services that struck me as being as effective as special services at home, and that the infusion of a small amount of money could have such an immediate, direct and dramatic impact. When the Windsor-Essex group was organizing that particular program, that day I was down there talking to people about being able to design and develop how you would use dollars to be of real help in your own homes in many cases, and so how do we begin to shift to incorporate that much more in programs?

My question is this: The previous government, and the present government is going to continue with it, the long-term care initiative which spoke to community-based care for seniors and those with physical disabilities—that was the initial thrust, and that is proceeding. You have said, and I have heard others say, if only there were sort of one place where we could go to find out about programs, to get direction which as parents we could access, because sometimes there are programs in communities and for a whole bunch of reasons people do not know about them.

Do you think we should be trying to envelop the multi-year plan more into that long-term care initiative, or is it simply that if we could enrich the special services at home program, the parental involvement in defining and what we should be doing, and really focusing on families, because I think both you and Eva earlier really underlined what looked like a need? Certainly there are needs that the child has, but the child is part of a family of whatever shape and description, and increasingly we know that there are more and more infants and younger children who are

now living much longer with greater needs, as well as those who are now adults whose needs are perhaps less.

How do we begin to attack this organizationally, because again, I think what we have to be doing here is trying to help move things forward. We can say, "Put more money into special services at home," and frankly I think any government, if it can, wants to put more money into those things, but are there also some things that we can do that, if we can get more money into them, will also make it a more effective system? From your end of the telescope, what are some of your thoughts on that?

1050

Mr Cartan: I think it is an extremely complex question. In terms of its relationship to long-term care, which has some similarities that we can see in this, I would advise extreme caution at this current time for a couple of reasons. One, the long-term care program in my community and in other communities has an extreme medical focus, although there are other kinds of integrated home-maker programs and other things that come out of it. For example, case managers are nurses in our community; 99% of them are nurses. So there is a medical perspective on the situation. It is, at the same time, not as easily flexible as special services is.

Also, the final thing, which I think is the most important thing in the province, is that special services at home allow the user of the program to have control over some of the resources. Things are accountable, but that is not replicated anywhere else. While not all families choose the option to self-direct a contract, you still control the resources in saying, "I want it to go here or here and they can help me implement." That characteristic is fundamental to any of the announcements that have been made about self-direction in this whole field. I think in that sense I would express some extreme caution around seeing the two melding so quickly together.

Mrs Friesen: I would just like to add that when I was referring to one place to go, it was more for one person to ask for help, not one place to go get your resources, because families need the choice. We have experienced where needs were not being met because of inflexible agency guidelines or whatever and we could take our pot of money and we could go there where the needs would get met. That is really important. People have to be able to choose where they direct their funds.

Mr Beer: I think that is an important point that I wanted to make sure we heard because it has come up. In fact, I think for those with physical disabilities there has also been that concern around the self-direction, the individualization which you speak to.

The Vice-Chair: I would like to move on to Mr Malkowski next on the list, and then I have several other members waiting. If you could be brief, we will try to get everyone on for some questions.

Mr Malkowski: I want to thank Mrs Friesen for her presentation and sharing her experience with us. You described your experience. Most of the previous information has been provided by medical professionals who describe it from a medical perspective or a deficit model. They say

all the things the children cannot, cannot do and then that of course influences the parents to increase their grieving process.

Do you feel that the medical professionals should change their focus from a deficit model to a humanistic model, and do you think that would help parents to feel less stress or have less negative feelings towards their child?

Mrs Friesen: Actually, that was part of my presentation I eliminated when Harry told me to speed up.

I was going to refer to the fact that not only the medical people, but other professionals who are supporting you operate from a medical model, which is: "Fix it. This is wrong. Let's go in and fix it." One example I was going to give that was not even related totally to the medical was that when we were in a state of collapse at one time and appealing for more dollars through special services at home, we were told by personnel who had the control of the money, which in our area was the institution at the time, if we just could not cope with what was there, the maximum, then maybe our daughter should be placed, which I could hardly believe because the answer was like if we could not manage, it was our fault.

One of the social workers sitting around the table who I think had just gotten out of university said, "Maybe I could give you some counselling," so it was like the mother needed fixing and everything would be fine, that kind of thing, and everything is like that, absolutely everything; and we have done a lot of work with parents in our community where we have said, "You have to start looking at your kid as a child first and even work with professionals," and we see change in our community.

However, across this province people do operate from like you say, the deficit model, and what really has to happen is that people look at the whole person and what does that whole person need to be part of the community. If it means support, you are there; it is not necessarily because something is wrong and we are going to fix it. It is because they are different and they need the support and would wholeheartedly agree that that does help parents if they can look in a more positive light that way at their children.

Ms Stone: I always say, with my son, positive versus negative, and if you look at him in a positive sense and all the things he can do as opposed to those he cannot then you see him as a positive, functioning human being instead of someone who is negative. I think that is a really important point to bring out. How you view that person and the amount of ability, even if he can only smile, that is something that he can give to us and I think it is really important to look in those terms.

Mr Malkowski: I have a very brief supplementary. Do you feel it is important that we have a hotline that could help parents on the phone giving them the opportunity to express their feelings as well as get information. By using this humanistic approach, do you think the hotline would help? Is there any way that parents can get relief?

Mrs Friesen: That is not anything I have ever thought of so I do not really know how to respond to that. I really want to be in favour in communities where people can get to know each other and network and support each other and I see that working in our community. A hotline, like I said, is just something that I have not even thought of. Possibly in communities where there is in fact networking going on it would be a help.

Mr J. Wilson: I have a difficult question and I guess it comes partly from my background. Prior to the election I was an assistant for many, many years, as Nancy may know, and also worked at Canada's Health ministry in the last couple of years. Time and time again when we meet with groups we hear the same thing, as Maureen mentioned and Michelle has mentioned and that I think a number of speakers have touched on, and it has to do with the government itself or the bureaucratic process, and just to take a step back—Douglas, I know you want to talk about the service aspect more—what can we do, in a nutshell, given the time limitations of this committee and the limited recommendations I think we will only be able to make? Should we be training our bureaucrats farther back in the system to understand parental needs?

It seems to me there is always that gridlock of understanding. Maureen mentioned that if you got along with your regional office, things went better for you. If they took the time to understand you, it was better. We talk about the need for flexibility and control and accountability and yet the bureaucratic mind and the governmental mind often is: "We live in a legalized world. What if something goes wrong? Can we trust the parent to deliver the service? Somebody might get sued along the way." I am looking for the miracle answer, I guess, but we talk about raising care givers; maybe we should be doing something farther back in the system. We can give all the orders in the world as legislators, but particularly my experience with Canada's health system, it seldom gets translated into the field. I have always looked to see what the answers there might be so I would be interested, Mrs Friesen, for instance, to know what your experience there is?

Mrs Friesen: Well, my feeling is that it is very simple. If the bureaucrats and the people delivering service just felt that families were that important and that they are important institutions and we value them, then we are going to listen to them. If the whole model is what the families say they need and all the bureaucrats—if it is written in their guidelines and it filters down to the area offices—and they know that families are the most important thing and what they say they need and what they ask for, we should give it to them. We should help them get those resources. We should support them in any way. So the bottom line is, it is simple now, as far as the training—if I can touch on the training—of staff people, in my experience, maybe because I am doing the training, I find I have a lot more success if the people do not have any preconceived ideas and have not been trained already at some community college. My daughter has medical needs and they manage, because when the parents who hold the key are doing the training and the asking, it can

only work. It is as simple as, if families are important, we have to give the workers who are in the families more money and we have to listen to what the families are saying.

1100

Ms Stone: If I was going to give you a magic answer, I would say that many families deal with many ministries. The co-operation between those ministries is less than nil in the sense that if you have a health problem and you go to the Ministry of Health, they look at you with blinkers and only see the health portion of your family. If you go to the Ministry of Community and Social Services for support mechanism, they look at you with blinkers and see only that section of your family. Somewhere along the line we have to get some co-operation between all ministries. Education is another biggie in the sense that if the Ministry of Education is running a program, there is no flexibility for sliding back and forth or for some co-operation with another ministry. They are all done with the blinker concept. They are looking straight ahead only.

I would ask you as a politician to begin to address some of that interministerial co-operation and some of the grey area that slides from one to the other. I think that is really important to families, because we often find we are dealing with lots of ministries, and we are dealing with them in quite separate ways and categories, as it were.

Mr Zwerver: I think there is one other piece of that as well. Unfortunately, the issue of training and attitude in some ways is not as different within the bureaucracy of government as it is in the community at large, so it is one thing to have corporate direction and corporate policy, but it still means that there are people who come out of a certain mindset, who come out of a certain level of understanding, of attitudes, who have grown up with a whole lot of myths around people who have been labelled and are going to have to deal with implementing some of those policies.

I think part of what we need to do is to be much better at beginning to deal with attitudes early on, with public education, and clearly we have to spend much more time dealing with some of those basic issues with the people who are hired to implement policy. That is true not just within government; that is true within the agencies and the structures. Parents have a lot to teach us about that, obviously. We have heard that this morning. I think that is just a very basic issue and it runs throughout the whole system, because it is a system.

Mrs McLeod: I want to take a moment to link a couple of parts of what you have been saying so that I can clearly understand it, because I think what you have been talking about for the last little while may represent some fundamental change in our approach to providing service. You began by talking about an inflexibility that systems tend to develop and went on to talk about the importance of providing a service directly to the family, so that the family can essentially design a plan that works for it. As I listened to you, I wondered if you tend to think of the family as being the parent and the child with the particular

problem that we are providing service for and fail to understand that the family is a larger unit that needs support.

I will take 10 seconds to think of one constituent I talked with recently, a single mom with a two-year-old multiply handicapped child with severe medical problems requiring fairly constant attention, who was receiving everything the system could give, special services at home, respite care through the voluntary organizations, Easter Seals support for medical treatment, extended family with informal caregivers, but it still was not meeting the need she had. The response was, "What more can we give?" What she was really saying was, "I need special services at home to be delivered outside of my home so that I can stay home and be with my four-year-old." Is that the kind of flexibility, that specific kind of thing?

Mrs Friesen: That is the kind of flexibility we want, for you to say, "Yes, if that's what you want, we'll do it."

Mrs McLeod: But that is where the inflexibility tends to come in.

Mrs Friesen: Yes, and in our community right now, where there are some associate families developing out of this respite program I was talking about, we have been told, "No in-home programmers from special services at home can go into those homes." So you tell me how some family that has young children is going to take care of my daughter by themselves for a week without a little bit of support. It is exactly what we are saying. There has to be flexibility.

The Vice-Chair: Perhaps we should move on to the next presentation.

Mr Zwerver: The next piece we want to focus on for a few minutes is the whole area of resources and employment, which is about, how do we use the resources of the community more effectively, not specifically family focus but how you deal with the wide range of supports that an individual needs within the community? What I am going to ask Doug to do is just briefly introduce that, and I have asked Gordon Kyle, who is our employment consultant, to give you a quick snapshot of what is happening in the area of employment.

As you know, in the multi-year plan, Challenges and Opportunities, reference is made to providing a new direction to employment for people with disabilities, with specific reference to moving away from the sheltered minimal employment opportunities to really supporting people to be productive in a very real fashion in the community. We are in year four and Gordon will talk to you a little about where we are with that and what some of the roadblocks are, and also, I think, share with us some of the directions that are possible at this point. We will try to keep this piece relatively short to allow for some questions at the end.

Mr Cartan: In terms of the resources in the multi-year plan, I think there are essentially, I guess you could say, two or three different aspects of resources that need to be looked at. One is the resources that are dedicated to individuals or families—special services is one example we talked about—but there are also resources dedicated to people coming out of institutions, nursing homes, that kind of thing. Those are what we call individualized resources

in our system. They have been available to people coming out of institutions. However, they, have not been available to people currently living in the community. That is a significant issue for us at this time, increasing the whole idea of the pent-up demand in the system.

In addition to the resources for individuals, there are resources allocated to the infrastructure, the people who are core-funded, the supervisors, the behaviour management people, the infant stimulation people, other kinds of things, the infrastructure resources. A subset of what has happened in terms of that in the multi-year plan is the wage compensation exercise, moneys, resources, allocated to strengthen the infrastructure. That has been a good initiative. We applaud that and hope that can be extended in the future so that there is more wage comparability inside the system.

In line with those resource allocations, a subset of all of that is, by 1991 is anybody taking a look at how the resources have been spent and changing it all around? If you had a company and were spending for 12 years on a piecemeal kind of approach—that is the way things grow in social services, a piecemeal kind of approach—would you not stop at one time and then sort of reorganize the resources differently because the demand in 1991 is not the demand of 1979? That is one of the key issues we are trying to look at right now in our system. Two key areas where we are looking at that is residential and employment. I think Gord is going to speak for a few minutes of the allocation of resources and how it affects the employment side of the equation.

Mr Kyle: I think the issues around employment are not significantly different than all the things we have been talking about this morning. We have seen that the multi-year plan has really called for a new direction and a new way of thinking about how we use the resources at hand. That is that we have tied up right now, or over the last two decades have tied up, a lot of resources into building basic rehabilitation systems for people. We have attempted for some time now to make people better, to take people with disabilities, put them in rehabilitation centres and prepare them in some way for community.

What we have found over the last several years is that the more effective approach to dealing with people with disabilities is to take them directly into their communities as with all the other services we have talked about here and provide them with the supports they need to make decisions about the type of employment they want to go into and that would be suited to them, and support them helping them to go out and meet with employers and find employment and then with support to go in and learn the job, to do job modifications and to retain employment over the long term.

This is not new to the ministry. I think the documentation that has been developed over the last few years following Challenges and Opportunities has clearly outlined what it is we want to do. The problem is that we are not getting to it. Quite a number of support-employment services have started in the province in the last few years, but it often seems that they are starting despite the efforts of the ministry. We have agencies going off and playing w

their own resources and digging it up, and often fighting battles with their area offices just to allow them to use the money they give them in a different way to provide a different type of service.

1110

I guess the good news in this is that the minister recently came out with guidelines around supported employment which laid out a lot of these issues and I hope that will give some guidance to the area offices in looking at new ways of providing funding to services. However, at this time I have not seen a whole lot of new action. In fact, a number of area offices that I have talked to just have not begun implementation of the policies, or in some cases do not know what I am talking about when I ask them about the guidelines. I think we need to get that information out. Clearly, we really need to look at where we are spending money and how we can begin to start realigning the resources.

The shelter workshop systems we run are very expensive and have a lot of resources tied into them. If we can find a way of moving that resource into supported employment, I think we can make a lot of effective change.

There are a couple of the key things that are stopping change from happening right now. One is that the workshops were traditionally set up to be places of work and to produce revenue. On the original funding basis they were all funded originally at 80% funding. The ministry provides 80% and they are expected to produce 20% of their budget through revenue. Clearly, if you are moving to a system of community supports, there is no room for revenue production and the new systems just will not support that.

I think one of the keys to addressing this is that in some cases we need some money to offset the revenue expectations that services are now expected to carry. I have worked with a lot of agencies in helping them look at their budgets and in many cases we do not even need additional money. I think that because of the costs it took to run sheltered workshops, in the purchase of supplies, in running trucks to get your supplies around and all the additional costs that this kind of rehabilitation centre called for, the money that they save by not doing that and by going to community supports—in many cases we are seeing that the services could run on the existing money if they were simply allowed to and were given some support from the ministry to make the transition to the new services.

Another area that we are going to need to address, however, is staff training if we are using existing resources to develop new systems. We have a lot of staff who are trained and who understand the old way of doing things. They are well versed in rehabilitation, but not necessarily in community support.

I got into this field in the late-1970s, running a sheltered workshop, and at that time when I did my budgets we used to normally slot in \$125 per staff person in the budget. I recently sat down with one of our local organizations to do a budget. They are still slotting in \$125 a year per person 12 or 14 years later. It just will not do. We have to get more money in there, at least for the next few years, to get the staff up to speed and really address that. In some

cases we will need additional staffing resources as well. A lot of the services we run could provide community-based service with the staffing they have, but that is not always the case.

Finally, I think that one of their real keys to success in getting into the community in the next few years is going to be the legislation around employment equity. We really need to get employers on side with what we are trying to do here and get more support from the community. We are pleased that the new government has said it would bring in employment equity legislation. That will be a very important component of this whole question.

Mr Zwerver: We are open to questions and we can elaborate on any of these points.

Mr Malkowski: I wonder if you are aware that there are services related to the Ministry of Community and Social Services. Often vocational rehabilitation counselors refer people to sheltered workshops or to employment training centres for people who are disabled. I wonder if that referral system needs to be changed to more of a supported employment opportunity. Do you feel that would help?

Mr Kyle: Yes, I think so, absolutely. What all our speakers have talked to this morning is the issue of individual plans for people, looking at the person, looking at his family, looking at the networks that are around them and beginning to develop those networks to support people. The traditional vocational rehabilitation services system of evaluation and assessment and rehabilitation just is not working in the new model and I think we really do need to look at all those questions.

Mr Malkowski: I wonder if you have any models of supported employment-centred models, whether in Canada or the United States, or an organization or some kind of model that you may wish to follow.

Mr Kyle: The United States is somewhat ahead of us on this and a lot of the models we are adopting in Canada we are kind of taking and modifying for Canadian use, so there are a lot of models of planning and support that came out of the United States. There are now, in Canada in the last five years, services that have done a very good job. We do have examples of quite successful services—one close at hand here.

The Mississauga association has been running a support employment service since 1984, I believe, and has had a great deal of success. It is a larger organization. We have smaller organizations all over the province that have done very creative things. One of our newer organizations is the Valley Association for the Mentally Retarded north of Sudbury that just never had any building based services and has been very creative in the development of the community, be it little towns like Nipigon and Red Rock up near Thunder Bay that took a very traditional building based service.

I think it was just a matter of a new director who came in and took seriously the literature that the Ministry of Community and Social Services had been sending out and did what it said it wanted her to do

with the money it was giving her. It now has an absolutely community based system running in a very small town with a very minimal employment base in that town. There are a lot of other examples. Yes, we do have good examples.

I think the key now is the planning components and that is what we are struggling with, finding good models for individual planning and figuring out how that planning mechanism links with people's residential and recreational options, as well.

Mr Jackson: I would like to follow up on Mr Malkowski's line of questioning. It is very good. He asked my first question, which was for examples and I was pleased you shared those with us, but on the point you made earlier, Gordon, with respect to change in format and cost analysis, has that ever been put to paper? Has that ever been analysed or are you aware of any reports?

Mr Kyle: Cost comparisons between the two different approaches?

Mr Jackson: Yes. You alluded somewhat to it and I did not know if it had been formalized or if it is just a gut instinct.

Mr Kyle: It has been done at local levels. We do have some. The Mississauga association I just mentioned has done a very careful tracking for its own purposes there, costs between the way of doing business as they used to do it and what it is costing now, and that has been done in various areas. I am not aware of a provincial or Canadian—

Mr Jackson: Okay. On the employment equity legislation issue, I have seen the statistics of what has been loosely referred to as the five identified groups, of which the severely challenged, the challenged, or as some may call it the disabled community, has been identified. I have a concern that within that subset of disabled that although the provincial average is high for disabled, access for children with developmental handicaps, they do not fare well within that group. Am I making myself clear?

Mr Kyle: I think so, that people with developmental disabilities would not necessarily do as well as other groups under—

Mr Jackson: The blind and the deaf and those without limbs are doing extremely well in the context of access relative to others and that is a concern for me. I do not want you to address employment equity legislation, but I want you to at least tie down a point for us in terms of within the community there may be some importance to advocate for that.

1120

Mr Kyle: If I understand your question, I think yes, sure, there is some concern that employment equity legislation will still leave employers going with—if they are legislated to hire a person with a disability, they will hire the person who is the least disabled and the most capable of doing the job at hand. I think this is where we need to marry the employment equity legislation with a strong support network, this type of system that we are talking about here around supported employment. The two need to

be done hand in hand. I do not think one or the other is necessarily going to do the job for us.

Mr Jackson: Might I suggest then that given that we are aware that it is a commitment, it might be worthwhile for us to be looking at models around North America which have succeeded so that we are ready when the legislation does come in order to have that fine-tuned input, and might I share that with the association publicly, as I have privately.

A final, quick question, Mr Chairman. It has to do with the economy we are in. I asked the minister yesterday if she had anything to share with us about the minimum wage policy and legislation which was dropped. You have not really talked to that issue.

Mr Kyle: We had a comment on it in the document that we are submitting.

Mr Jackson: We have not had a chance to read the documents. We are very much at the mercy of what you present to us verbally. The concern with that, also with respect to a slowed economy—we are not getting the numbers of contracts—and its impact on our workshops, if you could hit those two points very quickly. I will stop there with questions, but those were two that I really wanted to get some feedback from your association and perhaps you directly on.

Mr Kyle: If I understand the question, just to comment on the wage policy, we are very pleased to see that the direction that was being sought has been abandoned now. We had a lot of concerns about any attempt to evaluate productivity of individuals with disabilities and then pay them accordingly, to pay people less than minimum wage. Very clearly, people with disabilities deserve the same protection of law as everybody else and we have to get better at providing support systems to ensure that people can work at a reasonable level that warrants the minimum wage or better.

We keep talking about less than minimum wage. Minimum wage, especially if you are in the Toronto area, is an impossible level to live at. We have got to do better than that.

I think clearly there will be cases where we do have people whose productivity level is a real barrier to their employment and I think we will have to find models by which we can make some compensation perhaps to the employer or look at other approaches to it. But I think the Employment Standards Act set the standard that we want to see adhered to.

I did not quite understand the other question, but I think it was the productivity within workshops.

Mr Jackson: How are they going to survive if we are not getting the contracts in this economy? What impact is that going to have?

Mr Kyle: On what?

Mr Jackson: On the sheltered workshops. Are we going to tell them: "Just go home. There is no work"? What is going to happen? What possible recommendations could you give us?

The government talks about protecting workers and would like to make sure that we are protecting these

workers as well. They have a right to the same kinds of protections and interventions and supports financially which we are seeing in this very difficult recessionary time. What are you seeing happening, or do you have concerns? You have gone through one recession in this last decade, and this one apparently is going to be worse.

Mr Kyle: I do not have a lot of concern on the sheltered workshop side of things. Traditionally the sheltered workshops have been an inexpensive way for community employers to get subcontracted work done, so I do not hear a lot of concern coming up from those services that they are hurting. Where they have lost contracts, they have been able to pick up others because employers are looking for cheaper ways to do things. I have not seen that as a concern anywhere right now. Clearly it is a concern on the level of community employment, though, because there are people being laid off in all sectors and often people with disabilities are in the line of the first to be cut from obs as cuts are made.

I do not know that there is an easy answer to that other, than just making sure that we have supports so that people with disabilities are seen to be as valuable as other employees.

Mr Beer: Just one comment, I guess, having moved away from the ministry. One point I want to make about the wage policy is that I think, frankly, that you had made your case and that would not have gone forward in the way in which originally it was going. I know not only I personally but many others, as we looked at the pilot projects, had deep concerns about it, and certainly it is important that you indicate the new direction we are going now. But I think a case had been made and I just want to put that on the table.

The question I would like to ask you is one perhaps that especially those of us have who are from smaller communities outside the larger centres, although this may apply as well in Metropolitan Toronto and Hamilton and Windsor and Ottawa. It is around the role of the sheltered workshop. I guess when we meet with parents, whether it is through the OACL or other organizations, there is a lot of fear at times among parents when they hear that the local sheltered workshop is going to disappear. The concern is not necessarily about the individual or about his employment or rehabilitation or what have you, but just imply that in terms of a range of opportunities, I suppose, that exist in a lot of the smaller communities, that workshop plays a number of roles.

I do not think that I have found in my brief experience as an elected member of the Legislature an issue which, if you are at an annual meeting, kind of brings people alive. Seeing things like the Mississauga program and talking to the people who are involved and really realizing the thought that has gone into it and the individualization, and then if you just talk to the people first, you know that really is the way we want to go.

What are some of the things that we need to do? Clearly, as Cam says, if we are in a recession, that adds difficulty and so on, but in many communities those sheltered workshops are very much into the terra firma, and

you cannot be saying to people they are bad, they are all these horrible things, because the reason they are there is to provide help and people see them as being supportive. How do you work with that shift? I mean, it is an attitudinal shift, but it is more than that.

Mr Kyle: It is an issue I deal with a lot, and a key part of what I do in my job is support to our local agencies in planning for transition of service. I have learned long ago to be very careful. I never walk into a place and suggest that what we are planning for is to get rid of the sheltered workshop, because you are right, you cannot deal with the backlash because there is still quite a bit of support for them in some cases.

I think the key to it really comes down to what we have been talking about all morning. Again, it is individualized planning. I just recently had been working with one of our agencies on development of a new system of planning for people, and one of the things we are realizing as we go through the process is that by individualizing, working with families and working with people, we do not have to cut options from people. If, clearly, a planning process makes an indication that the person and the family and everybody involved is in support of the person staying in the sheltered workshop system, I do not think at this point there is any real reason to be moving people out of that system. Clearly, the sheltered workshops are not going to be disappearing in the next two years. It is a slow process of getting people into the community.

I tend to lean towards suggesting to people to deal with the people who want to get out of that system and to work in getting people, through the planning process, out. If people are wishing to stay where they are, then stay there. Down the road, that may not be satisfactory in the long term because you come to a real philosophical barrier at some point, I would think, where the agency just simply says, "We philosophically are for a community living organization and can no longer support being the people who provide the segregated service in this town." I am not sure what we will do when we get to that. I just have not seen any agencies that have actually got there yet, that have been so successful that they just do not have any need at all for their sheltered service. So I think as long as we are running them, let the people who want to be there stay there. Down the road we will have to deal with that.

I think also what we see is that the people who want to stay in sheltered services become fewer and fewer as they become more comfortable with the idea and see that the supports are working for other people's kids and for other people in the communities.

Mr White: I have a couple of questions that are quite related, and perhaps I could address those both to Mr Kyle and to also you, Mr Zwerver. What I hear from the earlier part of your description of the program and changes in the program is some difficulty in shifting, in terms of the personnel who are employed, from one kind of work placement, which I believe is the sheltered workshop placement, to the community-based program. Essentially what you are talking about is using the same people who had the earlier skills, and without additional

training moneys, without additional staff development moneys. Out of the \$125 a year, which nowadays pays for lunch if you include GST, you are expecting these people to adopt whole new ranges of skills. I will leave the other bit for a supplementary for Mr Zwerver along the same lines. How is that process working?

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Mr Kyle: It is working somewhat by agencies being very creative with whatever money they have and finding ways of getting the training, but that is not terribly well, necessarily. It makes the transition of service very slow, because often services wait until they have an opportunity to hire new staff and then go and find people who have some training and some qualifications to hire in. I do not know; it is a very major problem in it. It is not working well, I guess, is the answer.

Mr White: If I could, along the same lines, to Mr Zwerver, we had earlier an allusion from Ms Brown about the difficulty with increased service demand and of course, as Mr Kyle indicates, the changes in service requests and need for help in terms of infrastructure and the means of addressing those issues. I am wondering if you could comment on that.

Mr Zwerver: I think that is becoming a very serious problem. As Maureen indicated, if you have an agency that has grown three- or four-fold over the course of even four or five years, and when additional resources have not been made available to deal with the infrastructure question, then you really do get into difficulties around, how do you manage that kind of system, how do you provide the supports in-house that are necessary to ensure that service quality is being addressed, the training needs are being addressed for the organization, especially if there are not a lot of training dollars and it really is a matter of supporting it by the people that you have?

I think what is happening in some cases is, agencies are beginning to say: "Stop already. We can't cope with one more request. We can't take one more person out of an institution. We can't do anything more until we take a look at where we are, in-house." The way that used to be dealt with was by agencies being challenged to look at the fat that was in the system and by reallocating resources and doing all those kinds of things. Well, frankly, there is not much to reallocate any more and that is becoming a very serious problem, even with some of the larger agencies.

So really, I think for government it is now a question about if we are going to support a range of service options in this province, from very traditional kinds of models of community residences that are run by community living associations and other programs that are being provided by our member organizations, as well as providing parent-driven models and so on. I think it really is time to go back to some very basics. One of those basics, I would suggest to you, is not just around the amount of money that flows but also the flexibility with which that money can flow.

We have some legislation that I would suggest to you creates problems. We have the Homes for Retarded Persons Act, we have the Developmental Services Act. One is funded 80%, one is funded 100%. There is the whole issue

of community agencies trying to find local money through fund-raising to essentially provide very basic services to that community, children's programs that are funded at less than 100% because of a historic problem that has been there and people having to try to find the 3% or 4% in the local community. Yet essentially what is happening is, these agencies, transfer payment agencies, are in fact carrying out government's mandate. It seems to us to be unreasonable to expect that these agencies go back and compete with all the other services in the community that do not in fact have a mandated responsibility to provide a range of services when we have government committing itself to a challenge contained in Challenges and Opportunities, saying, "This is what we're going to do as a government on behalf of the people of this province to make sure that community living opportunities, truly individualized community living opportunities are going to be made available for all people, including those coming out of institutions, as well as supporting people who are already in the community." If that is government's commitment, then I think the dollars have to be there to do that.

The Vice-Chair: I have Mr Owens, who would like a final quick question on this segment, and then we will move on to the next segment.

Mr Owens: I may try the chairman's patience on the definition of "quick," but one of the success stories that I am aware of with respect to supportive employment is the Sunrise Janitorial Services here in Toronto. I am just wondering, in looking at recommendations that you folks might be prepared to make with respect to training people and preparing folks to get into employment, are we heading in the right direction? I am aware that there is a program or a model, social role valorization. Is that worth supporting? Does that head in the right direction or are we doing enough? Maybe that is a dangerous question to want to ask, but are we headed in the right direction?

The second is, Mrs Friesen touched on an issue that I am concerned about, cultural sensitivity. Are we doing enough, again, to be culturally sensitive to the whole problem of supportive employment, or are we slotting people into places where the family may or may not think it is appropriate? Due to cultural reasons, the family may or may not be able to communicate because of language problems and, again, not understand the reason why their son or daughter is in the situation.

The third issue that Mr Jackson touched on is, with the economy in a downturn, my understanding is, and you correct me if I am wrong, there is apparently a lengthy delay in terms of when a person is laid off and then when he can get back into the FBA loop in order to start receiving money again. Can you make some recommendations how we can close that kind of gap so that there is that economic support from the time of layoff through to when FBA kicks in, or whatever social service is required?

Mr Kyle: I think Harry will respond to the first part of this.

Mr Zwerver: I will respond a little bit to the second half as well. If you remember the Transitions report, it really did talk about how some of that loop can be closed

and I do not think we want to get into kind of going back through those recommendations, although Gordon may want to comment on that specifically related to supportive employment.

The answer to the first part of your question, which I think underlies the whole issue that you are raising, is that, no, we are not doing enough. The question I guess is, what is enough? Enough is only when we can respond to an individual's unique needs and be able to develop a range of supports for that person so that that person can truly be supported in community. Ultimately, that is where we have to come to. All the steps we have been talking about this morning and all of the things you have heard already in your committee deliberations are really pieces of that puzzle, and I think at this point, for a lot of people, it is a puzzle. We are trying to get all the pieces together. There are many different pieces to that.

I think philosophically the issue from our perspective, and I think it has been well stated by the parents who were here, is that we have to respect the individual needs of the person. We need to provide a range of options for people based on their needs and based on their skills and interests. There are no simple answers. We have a lot of history in this province of doing things well. We also have a lot of history of sometimes doing things well in spite of the systems and structures that are there.

I would suggest that one of the things we need to do very quickly is to take a look at some of those systemic questions. They have already been alluded to—program funding, model-building, legislative reform, all those kinds of issues. I think that really has to be the challenge of the government at this point. How do you make sure we have an environment within which all of these things can work, rather than people feeling like they are beating their heads against a brick wall because somebody says, "It doesn't quite fit" or If that is the kind of dilemma that we as a society are in, as an organization which advocates in this area we certainly continue to push for that. It is very difficult in a morning like this to be concrete and specific about every one of these issues. We have background documents for all of the things we are saying here today which we can make available to the committee. The fact is that it is a matter of vision. If we have a vision which is reflected in Challenges and Opportunities for the future of all citizens of this province, then we have to make sure that at least the systemic issues do not get in the way of that. That is the least we can do.

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The Vice-Chair: I think it is probably best to move on to the next segment. We are quickly running out of time.

Mr Zwerver: Moving along to a systemic issue, I am going to ask Orville Endicott to share briefly with you some of our concerns and our position around the whole area of advocacy. We are very pleased, obviously, with the announcement by the Minister of Citizenship recently that the province is going to embark on developing a province-wide advocacy system. What we are going to share with you this morning are some of the questions and concerns which we think ought to be addressed as this model is

being put in place and which I think you as a committee need to look at in terms of the broader scope you have in your deliberations.

Mr Endicott: I feel somewhat inadequate following the presentations you have heard this morning. Even though they are my friends and colleagues, I have to say I was very impressed with them. They are, without exception, very hard acts to follow. I have to do that also without the support and assistance of my friend Ruth Hatton from Oshawa, who warned me that she may have difficulty getting here. Ruth is someone who shares her home with another woman who has some very challenging needs, and maybe those needs this morning took precedence over my need to have Ruth here to assist me. She did have the foresight to do a one-page handout about particular cases she has been involved in and I will be happy to share that with you at the end of the session.

I guess I can take some comfort in the fact that I do not need to persuade people in this room about the usefulness of advocacy. One of the really interesting things is the degree to which we have had, across the political spectrum in this province, concurrence about something which is essentially a very revolutionary program.

We had first the articulation of the vision by a former Progressive Conservative member of Parliament, the late Father Sean O'Sullivan, in his review of advocacy in the province. We had then, during the latter half of the 1980s, a period of reflection and nurturance of the idea under the former Liberal government, and now we have the New Democrats in the position to announce that implementation is going to take place no later than 1992.

Mr Chair, can I get some clarification? Is this the same committee that will be studying clause by clause the package of legislation that the Minister of Citizenship announced would be introduced?

The Vice-Chair: I do not have word of where that legislation will be going. I cannot confirm that.

Mr Endicott: Maybe at least some of you will be participating in that process during the coming year, and I am sure some of us will have an opportunity in that process to come back and share our ideas with you.

What I wanted to do in a few minutes, and of course leave room for questioning, is to plant in your minds some of the things you ought to be looking for in the process of the introduction of this legislation and its ultimate implementation.

Advocacy is something you probably do not need me to instruct you about, but at the same time it is in danger of becoming a motherhood word that people assume they have commonality of understanding about. What I say sometimes to people is that the essence of advocacy is found in those three letters in the middle, V-O-C. Those same three letters are found in the word "voice." V-O, and then there is an I thrown in, C-E. Advocacy is giving expression to the voice of the individual, particularly, in our case, the voice of the individual who is vulnerable to loss of rights, to loss of autonomy, to loss of opportunity in our society.

The articulation of that voice ideally comes from the person himself or herself, and the advocate, then, is in the role of supporting and encouraging the voice that says, "I have rights, I have needs, I have entitlements." But there are times, as well, when the advocate will amplify that voice, augment it with maybe special knowledge about the individual's rights, and there will be times when the advocate will be called upon to actually be the voice for someone who literally has no way of communicating in language the world can understand what his or her needs and wishes are. You have heard people this morning who obviously have used the voice of advocacy in that context.

What I would also like you to keep in mind when you are considering the implementation of this proposal is that advocacy has to be independent. It has to be independent of government. It has to be independent of service-providing agencies, including service-providing agencies which are part of the Ontario Association for Community Living. Advocacy has to be—and this is clearly the government's intention—consumer controlled. It has to be accountable to and shaped by those for whose sake it exists. The minister's announcement was interesting, because I think she was trying to find a balance between not saying something vague and meaningless while at the same time not saying, "It's going to look like this and this and this," because the commitment is that the community is going to be able to have input and control about what advocacy in this province will look like.

There is another important thing for you to keep in mind. You have heard advocates this morning who are not part of an organized system funded by the government of Ontario. Whatever system does develop as a result of this legislation must not interfere with that kind of natural support that comes in families and friendships and existing community circles of support. We have to make sure our advocacy is not something that rides roughshod over those good things that are happening, but recognizes and validates them.

I have to say also something about the relationship between advocacy and substitute decision-making, because the government's announcement was that there would be a legislative package of three bills, not only establishing advocacy in the province but reforming the very badly outdated law of guardianship of adults, and also a third bill which would again deal with substitute decision-making but within the context of health care services.

This is probably one of the most difficult areas for you as legislators and us as advocates in the community to come to grips with, because when you really consider it, you are talking about two diametrically opposed phenomena. When you talk advocacy you are talking about empowering people, letting them be in control of their lives by supporting them, but when you talk guardianship you are talking about putting someone else in control of someone's life.

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We saw it coming, so we certainly were not taken by surprise, but it is kind of puzzling that those two essentially conflicting kinds of legislation and public programs are being introduced in tandem. I think there is a reason for

it, and the reason is that guardianship needs to be under the scrutiny of advocacy so that guardianship is not resorted to too easily. Right now people complain that guardianship is costly and difficult. If you make it easier, are you really solving the problem or are you creating a new problem, that people too easily lose their autonomy? That is where advocacy comes in, to make sure that autonomy is not lost.

I think we had better stop at that point so there can be some dialogue.

Mr Malkowski: Thank you very much for your presentation. I have been impressed. Something I would like you to know is that I am a parliamentary assistant to the Minister of Citizenship, and what was announced in the House is related to the introduction of legislation in terms of advocacy and guardianship. I think you will find that there will be announcements being made some time in the late spring.

In terms of the multi-year plan, I think this relates quite well. I wonder how you feel about the obstacles and how that might be included in terms of the multi-year plan. I wonder if you could inform us of what you feel are priorities.

Mr Endicott: Certainly advocacy is one of the most promising ways of dealing with issues of community living, where people are going to be able to understand that they have an alternative. One of the things we expect is that advocacy, under the terms of the new legislation, will have a mandate to see people who are institutionalized, to get to know them, to allow them to know they have alternatives which are available to them if they choose.

Of course, once they choose those alternatives, advocacy again can be a very strong support to make sure they receive support in the community, which, you have heard this morning, is so often wanting. You have heard very effective parent advocates, but it is not everybody who has a parent who is able to make that kind of strong claim to the entitlement of the individual, so we do need other advocates out there as well.

Mr Malkowski: I understand you have a lot of advocates. You are talking about advocacy and empowerment projects. I am wondering if the parents and other disabled groups are involved and how those two are related. Do you find that often there are conflicts between the parent group and, say, the consumer groups? Do conflicts happen?

Mr Endicott: There is potential for conflict, yes. Inevitably, when the system comes to fruition, those potentials will materialize and we will have to deal with them, hopefully with sensitivity and by respecting, as I said earlier, the genuine advocacy that happens already in family settings and in other natural circumstances.

I am glad Mr Malkowski brought up the scope of organizations that are involved. I would like to draw your attention to the existence of the Ontario Advocacy Coalition, of which OACL is a member along with some 25 or 26 other provincial groups including People First, from whom you will be hearing this afternoon. I wish like anything that I could be here to hear that presentation, but unfortunately I have to go to a meeting of the Ontario Advocacy Coalition so I will not be able to. I think you can expect to

have a very stimulating time with the delegates from People First this afternoon.

Mr Jackson: Orville, I thought it was an excellent presentation. Mr Malkowski has raised questions in the area I wanted to, but I wanted to add to his comment as well. Have you had an opportunity to examine the Weisstub report? You made veiled references to the third nature of guardianship; it is medical, and the right of an individual to refuse support treatment. Have you had a chance to look at that report? Not to deal with it specifically—I am aware of the report's controversial recommendations. What is the nature of your association's response to the government vis-à-vis the Weisstub report and/or some preliminary advice before we get legislation on guardianship? Those are my two questions.

Mr Endicott: To answer your first question first, I have not had a look at the Weisstub report, if you mean to actually read it. My colleague Rod Walsh, legal counsel for OACL, who is in the room, was part of the Weisstub committee. If you have particular questions about that, he would be in a better position to answer them than I. He does have a copy, because he showed it to me. I have had a look at it, only in that sense of the word. He has promised me that I will have a photocopy of at least the executive summary and recommendations, which I am looking forward to.

This association does have an obligation to assist you as legislators and other members of the community to look carefully at the issue of substitute decision-making and what its implications are. We are very hard pressed to deal with all the things that have to be dealt with; even with a wonderful army of volunteers, sometimes it is difficult to be timely in our response to these issues.

One of the encouraging things about the advocacy announcement is that it is going to provide to advocates in the province not only funding to support individual advocacy but to support systemic advocacy, which would mean that groups like People First, like other community groups, would be able to have resources, which it does not have now, to think through these issues and come and think through them with you, which I think is very promising.

Mr Beer: It is a brief comment I want to make, if you would respond to it. In a sense, I think I am also making it for Gary to take back to the minister.

As we go forward in developing the advocacy system, just as we have been concerned that we do not want a service system that is going to work with all of the people with developmental disabilities or with physical disabilities, that we do not want that model to be purely medical, we accept that what we are trying to do in setting up an advocacy system is not to develop an overly legalistic model. I fully accept that there are times when the full force of the law has to be brought to bear, but I suppose one of the great concerns that often comes up in this discussion is whether those who are working within organizations, working with everyone we are talking about today—there is still an essential advocacy role within your association, within any number of organizations. What I would hope, as we move towards setting up this indepen-

dent advocacy organization, is that the approach it takes is to go in to try to make things better, to use powers of persuasion as much as possible so we do not end up with just something where, in effect, every time the advocate comes to the door there is a sense that, "Well, today we will have a discussion and tomorrow we will be in court." I want to measure my words carefully, because I do think there is no question that there is a need for advocacy, but I think we have to be very mindful that we are trying to help people here, not simply to spend more time in court or in quasi-legal systems.

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Mr Endicott: The area of adult guardianship is one that has needed to be overhauled not just for decades but centuries. It goes back almost to the origins of our system of law. It is really just now that we are saying: Should we not be focusing primarily on helping people determine what happens to them in their own lives rather than focusing on assigning somebody else to make those determinations? When the minister announced that the centrepiece—that was her word—of her proposal was advocacy, that gave us great hope.

The Vice-Chair: We have time for one final question by Mr Owens.

Mr Owens: It is more a comment, to thank OACL for the presentation they have taken time to pull together, and the presenters. I know it is not easy for people to appear before these committees, but I think you have provided the committee with lots of food for thought. You have certainly provided me with some direction I need to head in as a government member, as well as a member who deals with community living organizations within my community. I thank you for giving me that direction and some clarity on this issue.

Mr Beer: I want to join Steve in expressing our thanks, but I would also like to note—and this is the bad news—that Harry is leaving the OACL I believe at the end of the month, as some members of the committee may know and some of us who have worked with him over the years. I know the tremendous job he has done there, both for the organization and in speaking on behalf of those with developmental disabilities. The good news is that he is still going to be working with families and children. I know we all wish him very well in his future endeavours.

Mr Jackson: I would like to echo those sentiments.

If I take my legislator's hat off, as an active member of the Burlington Association for Community Living I would like to ask why we did not have specific recommendations in the report. I ask that question not as a legislator but as a member of the association. We can cope with whatever report we get. The oral presentation was outstanding.

Interjection.

The Vice-Chair: You had better put your member's hat back on.

Mr Jackson: Thank you for the interruption. It is appreciated. This is my brief time for closing statements, which is what you are in the process of.

I simply wanted to suggest to you that we followed the brief very carefully—I have not had a chance to examine it—and it will be helpful, but I would have liked to see some specific recommendations. I hope there will be an opportunity for us to get them in the next 24 hours, because we are into recommendation-writing tomorrow morning. I will not ask the final question, but had I had time it would have been for you to give three specific recommendations to this committee that you would like to see in the report. Time will not allow that, so I leave that with you. Thank you very much for your presentation and all those who came today.

The Vice-Chair: We have run out of time. I will take this opportunity to thank you as well, because we had a long, interesting and very informative session this morning. You have brought a lot of people to the committee who have had the opportunity to add to our information. I think that is very worthy. Once again, thank you.

Mr Zwerver: Could I just respond very quickly to Cam's challenge about recommendations?

The Vice-Chair: One minute.

Mr Zwerver: What we tried to do in this presentation was provide you with a very broadly based series of issues and the concerns that come out of that, rather than specific recommendations. That was done very carefully. Obviously, we would be pleased, on the basis of the discussions today, to come forward with some very specific recommendations, because all of these actually are based in recommendations. We would certainly be very pleased to do that, and thank you for the opportunity to be here.

The Vice-Chair: The only way we can entertain those would be if you submit them before tomorrow morning. Once we start getting into our final report writing, I do not think they can be added.

In any case, we must move on. We have a very tight schedule today.

Interjections.

The Vice-Chair: Could I have some order, please? If you are going to have discussions, would you please do that out in the hallway. We must have our next set of presenters before the committee. Could I have some order, members of the committee? To be fair to our next set of presenters, I would like to move forward.

ONTARIO HEAD INJURY ASSOCIATION

The Vice-Chair: We have the Ontario Head Injury Association, Ray Rempel, before us. I am sure he would like to get on with his presentation. I thank you for being patient with us. We are under a time constraint and I need to move forward. As I have reminded all of the witnesses, we have half an hour for each presentation. I am going to have to hold you to that half hour. You can divide that up at the end or in the middle for questions. Whatever way you would like to do that is your choice.

Mr Rempel: There are so many issues and items we would like to get into with you specifically, but we felt we had to step back and try to make a point more strongly, and try to make the point in such a way that the minister would understand that a lot of us are used to skating uphill but it

is a tiring process. We need to have a much clearer dialogue and understanding between ourselves, as people who are of that vulnerable or fragile population and those of you who sit in the position to change situations for ourselves.

The mission of the Ontario Head Injury Association is to develop an environment within the province of Ontario that encourages people who live with the effects of a traumatic brain injury to recapture, to the greatest degree possible, the most productive lifestyle. Such a changed environment includes the development of educational, avocational, vocational and living opportunities of equal value to persons who live with the effects of traumatic brain injury as are available to the population at large within Ontario; and further, to alter the attitudes and understanding of society regarding the importance of the prevention of traumatic brain injuries.

I would like you to keep that in mind as we go through this brief.

Of the five stated outcomes that follow the mission statement, the two germane to this presentation say, "to significantly increase the number and types of resources that benefit persons who live with the effects of traumatic brain injury," and, second, "to undertake and encourage the development of research and educational initiatives as they relate to traumatic brain injury issues."

I guess one of my jobs today is to educate the honourable minister and those who work with her.

The original announcement by the minister to put on hold the deinstitutionalization process was a tremendous blow to the administration of the Ontario Head Injury Association, to the families who work with family members, and to those who have sustained injury to the brain. I will get into that in a little more detail later.

To provide you with the rationale for the statement that it was a tremendous blow, it is important for you to recognize that within the developed world and even within support agencies to the Third World, there is one common area of agreement that is a cornerstone of change, that is, to ensure to the greatest degree possible a most productive lifestyle for persons. That such a lifestyle could be considered as a possibility within institutional walls for a person capable of growing and living outside of those walls is reprehensible and naïve.

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Most devastating of all, in our thinking, was that in the past decades we have had to attempt to influence governments whose priority sometimes perhaps seemed to be more the economic viability of the country or the province than concern for disenfranchised Canadians. But even within that context, they worked with us to the extent that we could develop an interest, and strides were made. Tremendous gains in fact, including the bill in question, occurred within that context. Now in 1990-91 to have a social democratic government put that deinstitutionalization process on hold without presenting any substantial or horrifically validated reasons for the move is devastating and crushing to those of us who are directly affected by the move.

The most immediate and persistent rumour which has gone through the head-injury community and eroded confidence in the minister of the new government is that the freeze was the result of presentations by affected unions and their employees, more concerned to protect their status and wages than caring about the people they, to this point, have been purportedly serving.

Government, advocacy groups and those in the position of providing opportunity for the people in question must always diligently safeguard the rights and the safety and the humanity of what can be described as a subtly fragile and vulnerable clientele. But to callously and with disregard simply change plans and direction creates confusion and havoc and fear in individuals' lives. For some already fragile people who were in transition at the time of the announcement, it is just totally unacceptable.

The minister and her staff need to be reminded that change, if needed and if the political will is there, can occur without shutting down the process. In fact, as initial experience is evaluated, one would think that ongoing change in a productive manner would be one of the anticipated outcomes of such a project.

It is important that the minister and her staff recognize that a significant portion of persons affected by this transitional process are persons who in fact live with the effects of acquired injury to the brain. I want you to understand this, because the population of fragile people comes with a whole host of problems they cope with. Such persons as we are talking about here, with traumatic brain injury, should be recognized as having many and frequently most of their pre-morbid capacities, and much of the knowledge still intact and within themselves. The brain cells destroyed through trauma of course reduce the capacity to act out and/or perform with the same degree of intensity or skill as was the case pre-morbidly. However, the non-affected areas of the brain, as best they can, continue to function, and in the appropriate environment such a person will continue to develop in a productive manner. Likewise, unfortunately, in a counterproductive setting, that person will as well continue to develop but generally in a counter-productive manner.

For that reason alone, it is imperative that never again will persons who live with the effects of injury to the brain experience institutionalization as a first-choice option by health care professionals and uninformed family or friends, and that those already institutionalized will be provided support with appropriate skill and knowledge to assist them to live as capably as is possible with the skill and knowledge developed to assist our population.

A friend of mine and of the Ontario Head Injury Association, a man in his late 20s, has resided in an Ontario psychiatric facility for the past four years, not because of psychiatric illness but because of his inattentiveness, a common deficit following traumatic injury to the brain. Were he here this morning, he could dialogue with you at par on any issue you would want to raise. Inattentiveness, however, is his primary deficit. Even without life-skills relearning, he is capable of much of his own daily living requirements. Unfortunately, inattention is a hazard to oneself on the streets of any Ontario city, stepping out into

traffic specifically. Rather than an appropriate residential setting with adequate supports, we keep him in a safe psychiatric facility, and we do so because he does not have access to a residential program with appropriate supports and his mother is too elderly to work with him at home.

In 1989 we held hearings to determine the status of wellness of Ontario residents who live with the effects of traumatic brain injury, and he gave testimony. He said in part: "I can't participate in appropriate programs"—here at the institution—"because I am not yet a psychiatric patient. However, I live with psychiatric patients and if I stay here much longer I am afraid I will become a psychiatric patient."

In summary, it is of small solace to be told that the freeze has in fact been lifted. We trust that the minister, in an attempt to restore confidence in the population of persons we represent, will henceforth include us who live with the effects of injury to the brain, both through first-person experience and through the experience of supporting and befriending a family member or friend, to participate in any and all of the ongoing studies, discussions and decision-making that pertain to the treatment and planning for treatment of vulnerable adults.

Mr Owens: Without making any comment on the unsubstantiated rumour you have included in your paper—and it is an unfortunate inclusion in your document—I would like to agree with your statement about disenfranchised Canadians.

I had the pleasure of meeting the parents of a brain-injured child in my constituency. They had come in to speak with me about another issue, but very quickly the subject turned to the source of their problem, which was their child, 21 years of age, who had been attacked and was left with a serious brain injury. I felt a complete sense of hopelessness. As a matter of fact, I referred these parents to your association, on the types of services we could offer these parents in—again, the words "respite care" come up, the type of retraining that is available, the level of diagnosis we are able to do. This young man was a computer technologist with Bell Canada and the likelihood of his returning to that occupation at this point seems to be very limited.

What do we do with these folks? Do we keep them on some level of social assistance? Do we create group homes for brain-injured people? I guess what I am asking you to let this committee know is what kind of resources we need to allocate to that disenfranchised section of the province and quite possibly the country, and how we specifically address their needs. Do they necessarily have to be different from the way we address issues which affect the developmentally handicapped?

Mr Rempel: In regard to your first comment, we did not just glibly put that rumour in. We put it in because within the community of people affected, that is reality. We are not at all implying that that was the case, but we are saying that rumour went through that community quickly. You had better believe that that is what quite a few people believe. Fact or fiction is not the point. That is reality at this point, and you need to be aware of that. We

did not indicate at all that that was the way it was. Where it started, I have no idea, but that is the way it went through our community, and I think it is our duty to let you know that that is what occurred. It does not say that is what it was, it says "the rumour." We will leave it at that.

I appreciate your question about the resources. Coming out of the 1989 hearings were 33 recommendations. As well as those 33 recommendations, there were four specific projects that we felt had to be initiated in order for significant change to really occur. With the previous government we were able to initiate one of those four and there was a sensitivity to dialogue and work towards the additional, but one of the problems of a change of government is that things kind of go on hold.

The summary document of the hearings went out to a number of the ministers, I would say to about eight or nine ministers, who would have reason to relate to head injuries. I would be happy to provide this committee with that. It indicates the kinds of opportunities that are inexpensive opportunities, but opportunities that do not exist presently for people who have sustained injury to the brain.

1220

Independent living is definitely a place to start, and we are right now pretty much precluded from participating in independent living because we are not completely self-initiating. In fact, one of the common deficits is a lack of ability to initiate, albeit the ability to perform. It is just the nature of the brain, that once it gets twisted and torn and those synapses get scarred, one of the first things to go is an ability to initiate. However, once initiation occurs, then performance is there.

That is something that science is still a number of years away from being able to cure, so programs need to be developed to provide appropriate vocational and avocational opportunities for our population. The literature is there. The one thing that there is not is a dearth of literature on the kinds of things that are done in other jurisdictions, but really are not a part of any province. Our neighbours to the south and some countries in Europe are much ahead of us in Canada.

Mr Beer: We have a short period of time, and I wonder if we might just focus on the funds that were set aside. I would be interested in knowing and I think it would be helpful for the committee. If I recall, it was something in the order of \$7 million from the ministries to begin to provide help. I am just wondering how that is going.

Is that beginning to get into the communities and can you see some good things happening there? In building on that, what are some things that perhaps we ought to be looking at? Just as part of that, in terms of the approach to the head-injured community, should that be enveloped within and very clearly within the long-term care initiative, or do you see this as something that would be independent of that?

Mr Rempel: One of the real dilemmas that we have is that money going to traditional agencies does not really help, even though it is earmarked for head injury, because there is such a lack of education and there is also a misunderstanding. The kind of rehabilitation that occurs in reha-

bilitation hospitals is not the kind of rehabilitation or support that people with a blow to the head require, and so a physiotherapist is not generally of utmost need for that person. In response to Mr Beer's question, the money is there, but too frequently it is being put into traditional programs that are attempting to provide service and we are trying to fit that round peg into the square hole and it ain't working.

Neuropsychologists, for example, are probably the most important health care professionals for this population. OHIP excludes payment to neuropsychologists outside of a hospital setting. In regard to most programs funded by the Ministry of Community and Social Services—no reflection on your past work or on Mrs Akande—but the people out in the field have been taught to think, "Keep this program affordable." A neuropsych is, according to the people in the field, not an affordable health care resource, and so we will hire physios and occupational therapists, but we will not okay neuropsychs. That is some really elementary thinking, but that is the level that we are at with head injury services.

We are hoping that the new government will continue to look to the provincial Acquired Brain Damage Committee, because one thing that Mr Beer and Mrs Caplan did that we thought was very positive was to listen to that advisory committee and to begin to act on some of the recommendations. We trust that these ministries will discover it and will continue to listen to it. But we are dealing with a population that is described really by the leading researchers and clinicians as the research being in the penicillin era, so there is still an awful lot to learn about helping folks who have had their brains jostled about to really get back into a functional and enjoyable capacity in life.

Mr Malkowski: Your presentation has been helpful. Previously I worked as a vocational rehab counsellor and I found from my own experience that it was very hard to find services of a neuropsychologist in Ontario. It is also hard to predict if the person has a temporary head injury or a permanent head injury, so it makes it more difficult for the rehab counsellor to predict what kind of services would be required. I understand there is also a lot of stress on the families, having to take a lot of responsibility for those people who have been brain-injured. There have not been appropriate social adjustments and, as well, there is a problem with their thinking skills. I understand that we really need some kind of service, for example, attendant care to watch that person, to make sure that his rights are protected or the person is protected.

Can you make any comment on that situation? Do you feel that, if attendant care or neuropsychologist services were expanded and funding was provided for them, that would be helpful?

Mr Rempel: Yes. I think that the neuropsychologist really needs to be used more for educating the health care workers and professionals who work with this population than for further assessments on individuals in this population.

In response to the observation about permanent versus temporary disability, if you look at the neuropathology, you are born with all of the brain cells that you will ever have and you only lose brain cells throughout life. A line that should be interesting to you is that we all are shaped partly by the blows we have sustained to our heads from infancy on. Unfortunately for some, the blow creates a system of disturbance and damage that goes beyond what the brain can absorb and still have them function acceptably in society.

What happens presently is that damage will occur and generally a good neuropsychologist can look at that damage and can begin to assist this person to develop strategies to improve her quality of life, not necessarily to get her back at her job as a computer analyst, but to make good progress. But because we generally do not have access to somebody who understands the neuropathology and then the behaviours that are resultant from the neuropathology, what happens is that apparently the person begins to layer additional psychological problems on top of that base damage, because that base damage has not been identified correctly and the person provided with the appropriate opportunity for continuing development. We are laying problems one on top of another and, by the time she gets into one of the few transitional living centres in the province, she has such a host of issues that she is frequently not acceptable and ends up in a psychiatric facility, when really she could have been back at home as a functioning member of society.

What was the other question?

Mr Malkowski: If we could expand the attendant care service.

Mr Rempel: Yes, an informed attendant care service.

Mr Malkowski: What percentage of the people who are brain-injured is a result of accidents? Also, what percentage is a result of sickness, tumours, that kind of thing?

Mr Rempel: Approximately 78% of the injuries are vehicle-related. That would be bicycle, motorcycle, etc.

Mrs McLeod: I will make my question very brief as well, although I think this is a particular field in which we need to have much more awareness and information. I live in a community in northwestern Ontario which would be in terms of population a middle-sized community. My brief experience of direct work with brain-injured individuals was that you could receive physical assessments and physical therapy but virtually no psychological assessment or assessment that would identify what skills are remaining and how those could be utilized. I was hoping to hear you tell me that that is an exception because of our location, but I am hearing you say that is more the pattern than it is anything else.

Mr Rempel: It is that way in downtown Toronto.

Mrs McLeod: Assuming that we can get beyond that and recognize those needs—and your example is close to a

totally different type of example but a similar kind of situation that I experienced of residual skills being there and being unrecognized—to recognize what skills are there, to do that assessment, would we not need to go even beyond neuropsychology and break down some of the barriers between traditional service, for example, learning assessments, educational assessments, the kind of support that might be needed and would traditionally be offered to physically disabled people rather than brain-injured people?

Mr Rempel: A prime example of that is that in any foray that we try to make into the Ministry of Education, for example, school boards say: "We don't have a problem. We have Bill 82," and we say: "You have a tremendous problem. If you want to really help that person receive an appropriate education as opposed to providing a service to that kid, there is a hell of a difference. If you don't recognize the problems that this kid has besides the physical limitation, you're not helping that kid."

Mrs McLeod: And if the brain-injured individual is beyond school age, then I would think there is a real problem in accessing traditional learning assessment services.

Mr Rempel: Definitely, except in private practice which is not covered by OHIP.

Also, in response to Mr Beer's question about long-term care, we would love to feel comfortable that persons who sustained injury to the brain would receive appropriate opportunity through the long-term care initiatives. Just based on what we have been talking about here, the lack of understanding that even the health care professionals have, including general practitioners, we feel that we collectively, you politicians and those of us who work with the population, are in for some really unpleasant surprises when we attempt to have people who understand physical disability provide appropriate service to people who have sustained a blow to the head. We trust that there will hopefully be some flexibility there as that process is designed.

The other thing I would like to say is that this really is a large population. I can assure you that each of you in this room, although you may not have thought about it, either grew up with somebody who had sustained an injury to the brain or know somebody now as an adult. I know that is the case. You just think back to some kid you were in school with who was "strange" and was a real "behavioural problem." The list goes on, but I can assure you that you know somebody. The prevalence is really significant in this population.

We trust that you will continue and even speed up the process that we began with the previous government. We are sure here to support you and to back you in that.

The Vice-Chair: Unfortunately we have run out of time. I would like to thank you for making your presentation. We are adjourned until 1:30.

The committee recessed at 1235

AFTERNOON SITTING

The committee resumed at 1336 in committee room 2.

CANADIAN UNION OF PUBLIC
EMPLOYEES LOCAL 2191

The Chair: I call the meeting to order. I would like to call on our first presenters, CUPE Local 2191. Welcome to the committee. For the purposes of Hansard, identify yourselves on the record and then you are entitled to a half-hour for your presentation. The time is entirely yours. If you would like to leave some time for questions by members of the committee, that is within your rights as well.

Ms Faucher: My name is Francine Faucher and we are representing CUPE 2191.

Ms Maye-Chandler: I am Pat Maye-Chandler. I think we would like to start the presentation. We are going to be doing it together this afternoon. I will be doing the first part and then Francine and then in the recommendations I will do some again and then Francine. I think we will have plenty of time for questions.

On behalf of the members of CUPE 2191, employees of the Metropolitan Toronto Association for Community Living, MTACL, we would like to thank the committee for providing us with the opportunity to outline some of our concerns about the state of the social services in Ontario. In this brief we will present relevant background information and provide you with an overview of the problems as viewed by the members of our local.

It is no secret that community-based services for people with developmental disabilities are in the midst of crisis and that crisis has taken the form of an inability to provide urgently needed services. It is a crisis which can be seen in high rates of staff turnover, a lack of quality care provided to the individuals with developmental disabilities, wages which in some cases are literally below the poverty line, and hopelessly long waiting lists for existing programs.

A brief look at the situation in adult residences within the association, MTACL, will give you some idea of the extent of the problems. Last year our employer provided services to more than 4,800 individuals. In the adult residential services, there are 252 spaces available. At the end of 1990, there were 605 individuals from the community who were put on a waiting list for a space in a residential setting. Of the people on the waiting list, 198 were considered to be priority, meaning they were likely experiencing abuse or neglect, had aging care givers or their care givers had died. We offer these figures to reinforce our primary message to you today: this government must proceed with the ministry's multi-year plan but only after it has addressed the concerns of the present system.

We must also state clearly that expanded government funding is necessary for these services to survive in the coming years. Unless this happens, equitable wages and a safe environment for workers and their clients are simply unachievable. It has now become almost commonplace to hear reports of staff experiencing threats of physical as-

sault and attacks on other residents or themselves by individuals who are often dual diagnosed.

Providing services for people with developmental disabilities has traditionally fallen on the shoulders of three components of our society, those being family members, provincial institutions and community agencies. The main drawback of institutional care has been how it limits the access of people with developmental disabilities to community and family life. Families often turn to these institutions when they discover that they are no longer able to provide for the physical, emotional, educational and social needs of family members with these disabilities. Community agencies have the unique advantage of providing specialized and necessary services without imposing the restrictions and isolation of institutional care. They are, if you like to say, the happy medium.

Over the past 15 years or so in Ontario, the ministry has pursued a policy of deinstitutionalization, the net result of which has been that many of these individuals who were previously served in residential institutions have been moved to community settings. All of this has taken place during a period in which the demand for services from the community has greatly increased. While we firmly support this expansion of community agencies, recognizing the many benefits it can provide, we must emphasize that inadequate funding has severely restricted the level of services, such as the need for advocacy, housing, employment, education, public awareness and recreation for these individuals as well as the community at large.

Ms Faucher: Probably, more than any one issue, the whole question of staffing has taken on a sense of urgency within the social service community. A severe shortage of qualified and experienced staff combined with continual turnover of existing staff has made the provision of quality programs next to impossible.

It is clear to us that when existing staff are offered wage settlements of 1.5%, the message sent is that their work is considered neither important nor valued. The other message is that people with developmental disabilities are really not important members of our society. High staff turnover in community agencies is the direct result of low wages and high levels of work stress that we face on a daily basis. Sadly, the service provided by casual staff is often nothing more than custodial care. To make matters worse, workers in these agencies doing similar work as Ontario government employees are paid significantly less. Right now in Ontario there is a wage difference of 20% to 30% between ministry and community agency staff.

As our representatives at Queen's Park, we cannot impress upon you strongly enough that qualified and trained staff must be in place if residents living in institutions are going to receive the quality of care and services they need once they move into the community. We must not set them up for failure. Leaving familiar environment and people is often a traumatic experience. All supports must be in place before the move to minimize these traumas.

In our society, more and more parents have chosen to care for their children with developmental disabilities. They are, however, sometimes in need of time away from their children or are faced with a crisis situation where they need to have access to a parent relief service. This service is available in a few of the group homes within MTACL where a bed is allocated for this purpose. As you can imagine, the waiting list for this particular service is very lengthy.

A parent relief service is urgently and greatly needed in our community. However, it should be mentioned that in order to adequately meet the needs of the parents of developmentally disabled children or adults, this service should operate independently—and I do stress independently—from the group homes. This would ensure that appropriate assessments could be done by trained staff to provide the necessary supports to the parents and the individuals requiring the services.

We, the community, the government and advocacy groups must all put ourselves in a position to provide the appropriate community alternatives to the families and the individuals who have developmental handicaps. We believe that You've Got a Friend review of advocacy in Ontario must be implemented to ensure that advocates independent of the agency providing the services are available to ensure that all people with developmental handicaps are treated in a fair and humane way at all times.

While we have only briefly touched on some of the problems facing communities agencies, we have, hopefully, given you a sense of how urgent these problems really are. As things stand today, it is clear that everyone is suffering, the people with developmental handicaps, the families, the front-line workers and the community. We are in a crisis situation. Staff turnover, too much dependence on casual staff, obscenely long waiting lists, wage disparity between ministry and community staff, aggressive and threatening behaviours, again, are some of the more urgent problems which need to be addressed now.

Ms Maye-Chandler: We hope you will agree with us that our ultimate objective is to provide the highest quality of care possible. To that end, we recommend the following.

1. Staff should be hired in accordance with the current demand for services for people with developmental disabilities. Staff-to-client ratios must not be arbitrarily decided. Each setting must look at the particular needs of the individuals presently in their setting; for example, medically fragile individuals and those with histories of aggressive or disruptive behaviours. More staff time should be available to develop ongoing program activities to ensure teaching of life skills and promotion of independence for the population we serve. Existing programs must be on a continual expansion in order to meet the community need for today and future services.

2. Massive public education for staff and the community to ensure that integration occurs whenever possible and to make sure that all vulnerable individuals are protected.

3. Staff salaries must be increased to the levels paid to provincial government employees in similar positions.

This would require an increase in government funding to enable agencies to negotiate appropriate wage settlements. Equitable wages would encourage qualified individuals to enter our industry and would retain the services of existing staff which will increase the quality and consistency of services being delivered.

1350

Ms Faucher: 4. Independent advocacy groups must be recognized and implemented.

5. The document labelled Transitions must begin with implementation at stage 1. All individuals must live in the community regardless of the severity or type of their disabilities. Newer models must be developed to meet their needs. Staff must be adequately trained to provide these services. Resources and supports must be easily accessible to families, staff and agencies.

6. Government inspections need to be done on a regular basis. Inspections of all settings providing services for individuals who are developmentally disabled must be occurring on a regular basis, at random and without previous warnings.

Once again, we thank you for this opportunity to speak today. We will answer any questions you may have.

Mr Owens: I would like to thank both of you for your presentation. It is always nice to get that third component, the view of the workers in the actual situation as to what they see going on. I would like to ask a couple of questions with respect to recommendation 6, about government inspections being done on a regular basis.

Am I to believe by this comment that, first of all, inspections are not being done on a regular basis, and second, that there is some type of forewarning that is given to the particular home or group that is being inspected? The second question I have is with respect to parent relief. Again, we talked earlier about group homes having perhaps one bed available for respite care. I would like you to perhaps further comment on how that affects your role as workers in the group home and also how it affects the parents of the children or adults who are on what you determined is a lengthy waiting list.

I am wondering what kind of recommendations you could make to this committee as to how we as a committee can recommend to the government on improving that role as an aid to going forward with the multi-year plan devolving adults and children from institutions.

Ms Faucher: As far as the parent relief services are concerned, we do have a few group homes within the MTACL where there is a bed for parent relief service. What happens is that a parent brings the child, who may be an adult or a child, to the group home where other individuals reside. I am sorry; I am very nervous.

The Vice-Chair: Take your time, but we do not have a lot of it. I caught myself there.

Ms Faucher: The reason I was emphasizing parent relief service to be independent of the group homes is not to impose on the privacy of the residents who live in those group homes. However, the service is needed and there are more and more parents who do choose to keep their kids. After 25 or 30 years of keeping the kids at home without

taking a holiday, they need to have some time away. Now, how do I propose this solution?

Mr Owens: What type of recommendations could you make to the committee as workers in the situation to enhance the program? Do you see it going in a particular direction that it may or may not or should or should not be going in?

Ms Faucher: My idea is, in the group home setting, to have beds for parent relief service where the staff would be trained to take assessments and meet the needs of the individual on a short-term basis as needed. It would be not a residence.

Ms Maye-Chandler: If I can answer that as well, I work in the parent relief unit for children's services. Currently, we serve two different individuals. We serve clients on a regular, scheduled basis of parent relief, but we also serve clients who come in in a crisis situation. I have had clients who have come in after they have beaten up their mother and been beaten themselves and we have had to soak them for a long time in the bathtub just to find out what the damage is, and I get half an hour's notice.

Our employer has tried to change that and give us as much notice and knowledge as possible, but currently we often do not get any information except that a client is coming in in a crisis situation. The other thing is that the other community agencies that we are providing parent relief to, specifically for children, are now closing down, so where I work, we are it for the community. That is very sad because the idea is to try to help keep these individuals in the community with their families, and yet they are not getting the supports and in fact they are closing down.

Mrs McLeod: I would not mind pursuing the problem of some of the respite care facilities being closed down, because I have heard that on other occasions, but I think I will focus instead on the question of training, because you mention in your brief that adequacy of training is absolutely essential. Could you say a little bit about your feelings on the training that is available now? Are there enough programs? Are people interested in going into them? Are there any opportunities for extra training after they are out in the field?

Ms Faucher: There is opportunity for extra training out in the field, but now a lot of times, because we are working so short-staffed, your training is by doing. You are filling in and you are expected to fill the roles without knowing what the objectives really are.

After being in a position for a short or lengthy period of time, depending when the courses are offered, then you go into a classroom setting and take the theory aspect of it. So the training is limited. The turnover is so high that the training is continual. The people who have been there the longest are always training new staff. But if you are learning from me and I have a lot of bad habits—the training has to be more in depth in order to meet the needs. What we are finding is that a lot of the care that our individuals do get is custodial, without engaging in more independent living skills.

Mrs McLeod: Would most of the people who are working in the group homes be community college-trained graduates?

Ms Faucher: Some.

Ms Maye-Chandler: When I started working for the association 15 years ago, I was only in the second group of people to go through a community college program. Before that it was training in the institutes and it was hands on. Sad to say, I see it is going back to that. The community colleges are not able to attract people to the programs because of the shifts, the wages and all these things, so it is coming full circle again in terms of that. That is very sad.

1400

Mr J. Wilson: Just briefly, we have heard not only from you today but from other groups about the wage gap. Frankly, I do not really know what the wages are. Do you have sort of an average salary scale, for example, in Metropolitan Toronto? Second, what are the staff-resident ratios on average?

Ms Faucher: The staff-to-resident ratio on average is one to three or one to four, depending on the level of independence the individuals have. The wage gap is quite high. We have individuals who work full-time for the association. Their salaries start at \$17,000. In the residential setting, I believe it goes up to \$28,000.

Ms Maye-Chandler: I have worked there for 15 years and I now make about \$26,000 on top of working weekends, afternoons and all that kind of thing.

You asked the question about staff ratios. In residential, there are kinds of guidelines which need to be expanded and changed, as we said. We feel that there needs to be more on the guidelines of the needs. We have group homes now where children who need to be tube-fed are known to have aggressive, destructive behaviours. Also, Francine and I are both in the residential setting, but we have members from vocational services in our local. There is a great deal of concern in terms of giving some kinds of ratios in staff to clients there. Some groups have 20 clients to one staff in their vocational settings, some have 10, some have eight. There are no basic guidelines in the vocational area.

Mr J. Wilson: I thank you, because it is helpful to hear the actual figures. We have heard a lot of statistics today on percentage gaps.

Mr Malkowski: Your presentation gave us a broader understanding, but I have specifically two issues that I would like to focus on. Can you tell me roughly what a shift schedule would look like in terms of how many staff are working and how many clients would be in the residence, for example, in the morning or afternoon or evening shifts?

Ms Faucher: Again, it depends on the residents. Our residents are an aging population now. We do have quite a few group homes where the residents are retired. In these homes we have one staff for six clients. When the other residents who are at work during the day come home around three, there are usually two staff on, but again it depends on the need, from maybe three staff to eight residents. It depends on the setting.

Mr Malkowski: If staff call in sick or arrive late or you have a staff member who quits, does that force the other staff to work a lot of overtime?

Ms Faucher: Depending again on the setting. In a lot of the homes, when staff call in sick or are late, they will call a relief list of individuals who can be called in or we ask our part-timers. But most often, especially these days, we are using more and more agency staff. That is what we were referring to when we were talking about casual help. These individuals are mostly trained in the health care domain to provide the immediate needs. That is the dilemma we are in right now.

Mr White: I am struck with the kinds of long-term effects you are talking about here in terms of the poor remuneration. You are talking about an incredible turnover; basic services only being provided by health care aides; feeding and continence issues. I am wondering if you have comparative figures for OPSEU workers in the residential facilities. What is the relative wage gap?

Ms Faucher: The information I gathered was between 20% and 30%.

Mr White: And this issue has no doubt been addressed by your union on many occasions.

Ms Faucher: Definitely.

Mr Jackson: I deeply appreciate this brief and putting it in recommendation form is very helpful. I wanted to thank Pat for her candour but after 15 years, to be making that wage, I wanted you to know I have no consolation for you, of course, that with 15 days' experience the waitresses in this building make more money than you. The waitresses in this building are earning more than you are, with full benefits. There is a lot of disparity beyond the own-industry example is my point, but thank you for your presentation.

COMMUNITY LIVING ALTERNATIVES SCARBOROUGH

The Acting Chair (Mr Miclash): Our next presenters are the Community Living Alternatives Scarborough. Welcome to the committee. As you know, we have a half-hour presentation, whichever way you wish to break that down in terms of presentation and questions.

Mr Meldazy: Members of the committee, I would like to thank you for having me here today and giving me the opportunity to address you. My name is Bill Meldazy and I represent an organization known as Community Living Alternatives Scarborough, whose acronym is CLAS.

I would like to introduce some of our people here. Kay Anderson is our executive director and she is responsible for the administration and the operation of our group home; Bill Sparks is a member of our organization and also a parent of a handicapped child; Terry Francis, sitting in the audience, is the vice-president of our organization and also the mother of a handicapped child.

CLAS is a non-profit organization and a registered charity with Revenue Canada. Presently, CLAS has 42 members who are supporting developmentally handicapped children at home. The average age of the parents is

65, but some of them are in their late 70s with dependent children ranging in age from 19 to 45.

Our purpose is to provide supportive lifetime housing in the community for our children while our health permits in order that they not suddenly have to be placed in unfamiliar surroundings. In this way, we are able to prepare them for their eventual separation from us.

CLAS was incorporated with the intent that it would address and reduce long waiting lists for residential placement. Most parents have been on a waiting list for more than 10 years with no hope of placing their child in sight. This parent group took an active role in forming our association by planning, fund-raising, holding meetings, political lobbying and whatever.

CLAS's objective is to ensure that our children will benefit from participating in a positive and supportive environment which will encourage growth and independence. Their parents and family members will have the new experience of feeling secure in the knowledge that their family member is comfortable and well cared for. The parents have never complained about keeping their children at home, but life has passed quickly and now help is badly needed.

No parent of a handicapped child is ever free. They for ever worry and are still doing parent-child things, such as dressing them, driving them and teaching them, even after more than 30 years, nor are they able to retire once their children become adults, as are parents of normal children. Many parents have no supportive family or friends to assist them and must sit at home with very little opportunity to get on with lives of their own. There are parents who have never had a day off or a holiday without their child.

Handicapped children are now living longer, primarily because they have no social problems such as drinking, smoking or overeating, but also because as children they are under very little stress due to their dependence on others for assistance, advice and direction. They display stress only when they have displeased someone or are unable to do what is expected of them.

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Some years ago, institutions became acceptable because parents felt that their child would be cared for in a reasonable manner in these establishments. However, those presently being discharged from these same institutions are displaying emotional problems when they are suddenly thrust into a new social environment and expected to fit into a family atmosphere after having spent their entire lives in an institution.

It is imperative that we now start to introduce transitional programs for those being discharged from institutions which will give them the tools they need to adjust to a totally new and foreign lifestyle. CLAS is prepared to offer whatever assistance we can to support such a program. The basic necessities of life are not enough. Those people must be given a place to work and to play and, above all, they must be given the necessary tools to enable them to be integrated into society to the greatest degree possible.

Following are histories of a few of our members, whom I know personally, and their children who are still living at home.

Mrs A has been a widow for 18 years. She is 68 years of age and her son is 39. He is attending Monsignor Fraser College in a literacy class for part of the day and is home on all school holidays. Mrs A is also the grandmother of a 30-year old Down's syndrome child.

Mrs H is a widow, 70 years of age, who has a heart condition. Her son is 42 and working in a sheltered workshop. He too has a heart problem.

Lorne is 78. He has such severe emphysema that he must always carry an oxygen tank and wear a mask. He must also sleep with this equipment. His wife is 72 and his daughter, who is 30, works in a sheltered workshop.

My son Glenn is 33 and now lives in our first group home at 9 Courtlands Drive in Scarborough. At the time Courtlands opened, Lorraine and I did not anticipate Glenn's living away from home for some time. However, when we asked our son if he would like to do so, he wholeheartedly agreed. He had the best of both worlds to choose from and the choice was his. In late September 1989 Glenn moved into our group home and adapted to the change immediately. Lorraine and I went on a holiday last February without children for the first time in almost 34 years and felt quite lost for a couple of days. Lorraine died suddenly in April 1990, at the tender age of 63, just seven months after Glenn entered the home. I alone could not have coped with Glenn and I firmly believe that the events in my family were prearranged by our Saviour. Lorraine's death has caused many people to reflect that perhaps time does run out before we expect it to and before we are able to make our preparations.

CLAS has received approval in principle from the Ministry of Community and Social Services and has been given firm approval from the Ministry of Housing under the federal-provincial 1991 program for funding for another group home to accommodate six persons in 1991. We have 11 parents, many of whom are seriously ill, who are very anxious to see their children secure as soon as possible and we expect our new home to help in this regard.

One of our parents stated that membership in CLAS was like having an insurance policy in that the parents are assured of having someone to take care of their child when they are unable to do so.

CLAS's board of directors is planning to expand beyond the services we are presently offering. Ultimately, the organization intends to serve a maximum of 50 to 60 lifetime residents and some of the programs being proposed for the future are residential programs, respite care, service for complex needs, employment support and semi- and independent living programs.

In closing, I would urge you to continue on your present course of deinstitutionalization. While there are certainly weaknesses and problems which need to be addressed with respect to this process, it is very clear that large institutions are not a viable alternative to community living residential programs such as the one offered by CLAS. Institutions are simply not equipped to enable our

disabled population to realize their full potential and we cannot continue to deprive them of what is surely one of the most basic of human rights.

Mr Owens: I would like to begin by thanking Mr Meldazy and his group for the presentation this afternoon. CLAS is a fairly unique organization that exists in Scarborough. Could you tell the committee a little bit more about how you operate and the kind of parental assistance that is rendered to the clients within the group home? I think it is an excellent example of how community-based group homes can be run and I think perhaps we should be looking to CLAS as a model when we start looking at community-based programming.

The second issue revolves around the senior parents of adults and the kinds of supports that you see lacking within the community as of today in 1991 and what kind of recommendations you think this committee would need to hear to present to our government with respect to dealing with the population that you addressed in your report.

Mr Meldazy: The parent support. We are responsible entirely for what is happening in the home today. Our board of directors is composed of parents in the association. We have a hands-on on what is happening in the home. We assist our staff, our executive director in every which way possible. We assist in furnishing the home. We assist the staff when it is necessary, when they require assistance, such as when they might not have adequate staff on hand. We do a lot of the landscaping around the house. We just have a real hands-on situation there.

Mr Sparks: I think CLAS is relatively unique in that the composition is predominantly parents who are moving into what is euphemistically called their golden years, my wife and I probably being one of the exceptions since our daughter is only 18. We got involved for advice and support, but I agree about the insurance policy. We are not going to drop our membership, because time does slip away fairly rapidly.

A group of parents in Scarborough had continuously expressed their concern and in some cases their panic about what was going to happen to their offspring because they were getting progressively more ill. One of the two partners of the family would disappear and the person who was left would be doing his or her best to cope. They worried about what happens at the next stage when they are gone and, in many cases, there just are not other family members available.

The kind of nuclear family that we looked at 100 years ago with everybody in the farmhouse just does not exist. The closest relative might be in Vancouver or somewhere, and to take a person who has lived in the community for 40 or 50 years and ask them to move somewhere else to be perhaps in a group home near a sibling would be extraordinarily difficult. So the group on its own, with support, created the board structure: what its membership would be, who could belong and who could not. I think its strength is the fact that it continually monitors what it is doing and where it is going.

One of the criticisms that has been forthcoming for some of the larger agencies is that when they get too large

there comes a feeling of impersonality; no one knows to whom individuals are accountable. I think having set a maximum of the number of people over a few years that they can handle is one of the strengths of this group. They are not going to try to solve this problem for everybody in the world; they are going to try to solve it for their own group and then offer their expertise for other people who have the same needs to begin their own groups that they can monitor.

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Mr Owens: With respect to the comment about ongoing evaluations on the effectiveness of your programming within the group home, can you tell me how you go about doing that and what you do with the results after the evaluation is done?

Mr Anderson: We have our independent program planning in which we involve the parents. At that time the parents also have a say in what their sons and daughters are involved in, what other programs they would like to see and their impressions of how the house is being run and functioning.

Mr Beer: Your presentation was very interesting. It seemed to me that you underlined an area that is very important for us to understand centrally in the work that we are going to be doing in coming up with recommendations around the older parent. I am particularly interested in and had the experience of meeting with a couple of groups over the last year, one of which was based in Kingston, which had come together to try to find and develop linkages, particularly among groups where we were talking about parents who were over 60 or 65. I think you described the kind of fear and panic at times, where suddenly the parents' health could change very drastically and what would happen.

Are you aware of other organizations like yours, or do you see a need for perhaps particularly older parents to come together around some issues that while they may touch everyone are even more key for you, and are you also part of the Ontario Association for Community Living? Do you link in that way as well?

Mr Meldazy: Yes, we are associated with the Metropolitan Toronto association and indirectly, of course, with the Ontario association. We are members of the Metropolitan Agencies Representatives' Council, and I believe there is one other organization in Metropolitan Toronto that is similar to ours. Is that correct?

Mrs Anderson: They are parent founded, parent based.

Mr Beer: I was dealing specifically with older parents.

Mr Meldazy: We are not aware of any other association dealing directly with older parents. We have spoken to people in the Richmond Hill area, other families who are interested or who have seen our program in operation. We have spoken to them and they are presently trying to form a group of their own. We have had requests from other parents who have more severely handicapped children than we have at the present time.

I think what we have to get across to these other parents is to try to encourage them by some means to get together and form an association. We would be only too happy to assist them and give them everything that we have learned and tried over the years. There is a very definite need, not only in Scarborough. There are a lot of parents in Scarborough who are reluctant to come to us. I do not know why.

Our organization has grown very quickly in the last two years. There are other people who are scared to come forward. A lot of parents are scared to come forward because they do not want to be publicized. I feel that we have got to try and break through, we have got to get through to these families. We would be only too happy to assist them any which way we could.

Mr J. Wilson: Bill, on behalf of all members of the committee here today I want to extend our condolences for your loss in your family. We certainly appreciate that you have brought the message to us in a very personal way and we appreciate your being here today as with the other witnesses.

I do have a question, though. I too have a CLASS in my riding: the Clean Living Association of South Simcoe. You may be familiar with it. It just started up a home with five residents. I have some background in the length of time it took them to get the home up and running and I was wondering, in your particular case, how long does it take from the time you think you have established a need for a group home to actually get it running? It is important when we are deinstitutionalizing people or taking them out of the parental home.

Mr Meldazy: We got incorporated in 1988. Immediately upon our incorporation we started to pursue the necessary channels to get the funding. I guess from the time we made our first application—

Mrs Anderson: It was 1987.

Mr Meldazy: When we first met it was 1987, but I believe it was 1988 when we submitted our application for funding to the ministries' offices. We received approval from both the Ministry of Housing and the Ministry of Community and Social Services about October 1988. The funding for the home, cash in hand, was not available until January 1989. We purchased our first home in January 1989 and we opened up in September. So let's say about a year and a half from start to finish.

Mr J. Wilson: That is very good. You must be good at working through red tape.

Mrs Anderson: That is not the norm, though.

Mr Meldazy: That is not the norm, of course. We were pushing.

Mr White: I would also like to express my condolences to you. Certainly in terms of timing, as you mentioned, at least have a break with your wife.

The question I had was something following the lines of Mr Beer's. At the time of your organization, did you receive any assistance from the Metro association and from the OACL?

Mr Meldazy: Yes, the Metro association. We received some assistance in the form of advice and so on. We spoke to several people in the Metro association. People did come out and address us. I cannot recall some of the names, though. It has sort of slipped me right now. But there were people from the Metro association who did give us advice.

Mr White: And from your experience, you found that advice to be somewhat helpful, I am sure.

Mr Meldazy: Oh, very definitely. Yes, positively.

Mr White: Do you have any suggestions as to how a group such as yours could be enabled at the grass-roots, beginning stages?

Mr Sparks: The starting up of an organization, making it a registered charitable foundation, making it a corporation, is incredibly complicated. People from the general population just do not have the expertise. The original founding group that worked together to produce CLAS had the advantage of advice from the Metro association and actually met in its Scarborough offices free of charge, because many of the individuals were members of the other organization but knew that there was not a hope of getting into a group home.

They also had free support from a lawyer for advice and were able to tap, through OACL and through MTACL, people who could shepherd them through the process. What we were hoping to do is to create people at CLAS who could then take others through the same process so that you would get a pyramid effect so that people became experts at how to work through bureaucracy. There was a lot of very careful shepherding of this group so that they did have a home within a year and a half. It is a year and a half later and the second one is still in process. It does take time.

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The best we can offer is that there is a network available. The hardest part, as Bill said, is to get the first group of parents who are willing to sit down and talk about their problems and who their offspring are and what they want to do about it, because they have their own lives, their own responsibilities, and it takes an incredible amount of time. Bill has put in countless thousands of hours in the beginning of this process.

The Vice-Chair: Thank you very much for appearing before the committee. I think you brought a very sensitive story to us today and we appreciate your sharing that with us.

ADVOCACY RESOURCE CENTRE FOR THE HANDICAPPED

The Vice-Chair: We turn our attention to our next set of presenters. We have to move quickly along. The Advocacy Resource Centre for the Handicapped, Harry Beatty. Welcome to the committee. I would like to remind you, as I have done with each of the presenters, that we have approximately half an hour for your presentation. I will stick to that half-hour limit and allow you to divide that time up in whatever fashion you deem fit so you can allow for questions at the end of your presentation.

Mr Beatty: In the interest of time, I will not read our submission but simply summarize it.

I am not going to say very much about our own centre, except that it is a specialized community legal clinic which has operated since 1980. It is supported by 40 disability organizations. Because of our structure, a majority of our directors and a good number of our staff are themselves persons with disabilities. I have put a brochure in your materials describing ARCH more fully. If you have any additional questions, you could ask Mr Malkowski, who was a member of our board until September.

Personally, I have been a lawyer at ARCH since 1986, but prior to that time—

Mr Malkowski: On a point of clarification, if I might, I am not a member of the board of ARCH.

Mr Beatty: No, not now, but prior to September, prior to the election.

Mr Malkowski: No, I have never been a member.

The Vice-Chair: Perhaps we can clarify that later on if you like.

Mr Beatty: Prior to joining ARCH I was with OACL for seven years, so I have spent 12 years now advising on legal problems and critical issues relating to people with disabilities.

On the first page of our submission we have outlined some of the circumstances in which people who are developmentally handicapped find themselves in Ontario in 1991. I know that during your hearings you will hear about these circumstances from people who have lived them and are, therefore, much more qualified to speak about them than I am, but even having to advise on these problems is something, I think, that would have to affect you deeply. Simply to be faced with these circumstances and to have to tell someone there is not very much I can do about it is a difficult thing.

There are still people who have spent and will spend their entire lives on institutional wards without any family contact, basically without any friends, or at least friends external to the institution, and without any personal privacy. I am told as a rule of thumb by people who work at institutions, and I have visited a good number, that perhaps a third of residents will never receive any contact from family and another third will have only the most nominal contact, an occasional letter or perhaps a once-a-year visit. Only a very small number have any regular contact.

There are still children in Ontario who are living in group homes—and I am thinking of, in particular, some individual families who have contacted me—rather than at home with the family because funding is available in the group home but it is available only to a much more limited extent, if at all, when the child is at home with the parents.

We are still institutionalizing children in Ontario. The Provincial Auditor's report recently identified 130 children in schedule 1 and 120 children in schedule 2 facilities. Children labelled developmentally handicapped still are often not permitted to attend the neighbourhood school with their siblings. People labelled developmentally handicapped, children and adults, female and male, are subjected to physical and sexual abuse much more frequently

than others in our society. There is substantial research being conducted by Professor Dick Sobsey at the University of Alberta which is referred to very briefly in ARCH's abuse publication, *Responding to the Abuse of Persons with Disabilities*, a bilingual publication which is being distributed nationally.

There are still too many examples of inadequate care and life-threatening neglect. As the previous presenters explained so eloquently, people even in their 80s and 90s who have been looking after their sons and daughters their whole lives are faced with the terrible dilemma of allowing their son or daughter to go to a boarding home or an institution, if that is even available, because group homes are not available, or else continuing to shoulder the burden themselves. I would venture to say that is a women's issue, in that if you really examine what has happened in these families, in many cases the great burden of the care has fallen on the mother, although that is not always the case. A final example is that many people in Ontario labelled developmentally handicapped are still in sheltered workshops making 25 cents or 50 cents an hour, with little hope that that will ever change.

These things have all been documented many times, and I am sure others will tell you about them. The question is, what is to be done? Reviewing the announcement to the Legislature of the minister, Mrs Akande, I think there are a number of things there that ARCH can enthusiastically support.

It is good to see that People First of Ontario, which is presenting next, has been identified as a key group to be consulted, because too often in the past debate on these issues has proceeded without the people most directly affected, the people who actually live in institutions. It is often more or less assumed that they have no voice, that there is nothing worth while that they can say. At last I think this is starting to change as ARCH strongly supports consumer movement and established funding for organizations like People First.

We see in the minister's announcement some support for the special services at home program and individualized funding. We see the announcement of a forum in which there will be participation of all involved parties. We stress again that has got to include the people who have lived with the label of being developmentally handicapped.

Clearly, the area of deinstitutionalization has been a highly political one and approached—you were around for some of the history around the five-year plan—in a very adversarial manner in the past by, I would venture to say, pretty well all of the interested parties. We need some kind of forum in which a more constructive discussion can take place.

Finally, ARCH is an active member of the advocacy coalition and a long-time strong supporter of independent advocacy, going back to our role in Judge Abella's report on legal services and advocacy for people with disabilities in Ontario. ARCH, of course, is involved with organizations and individuals with all disabilities, or as far as we

can, and certainly we welcome all disability groups and serve clients with all disabilities.

Developmental disability has been a significant part of our mandate. We responded to over 200 summary advice calls last year involving developmental disability. Many major provincial organizations dealing with developmental disability are of course part of ARCH. Included in the materials is a report of a conference, although not a traditional conference, held in 1988 called Let's Talk and Listen. It was a conference to which there were many present and former institutional residents invited. Through skits, pictures, different kinds of personal interaction, some institutional issues were identified.

We view ourselves as a resource to the disabled community rather than spokespersons for it, and if we can encourage you to all support a wider voice for People First and other groups directly representative of individuals labelled as disabled, I think that is the main message we could bring today.

There are some ideas that we have put forward for improving the multi-year plan, classed under three headings. First is a better recognition of the rights of citizens with developmental handicaps in Ontario. Residential services and other services to adults are offered under the Developmental Services Act and the Homes for Retarded Persons Act, which have really not been amended since the 1970s. They were very progressive pieces of legislation when introduced, but now they need to be updated. They do not say very much about people's rights or about even basic quality of service except for some minimum standards in the regulation. Some of the important rights provisions in the Child and Family Services Act were passed by this Legislature but never proclaimed in force.

But it is not just a matter of legislation. Again, we come back to the importance of talking to institutional residents. For example, in visiting people who have been in the institution and placed in the community, there is a real concern on their part that existing relationships which they had would not be respected. It is important to remember that even though we may not agree with the institution as a setting for individuals, if they have lived there their whole lives or a good part of their lives, that is where their friends are. Residents would express concern that they would be placed in the community without a boyfriend or girlfriend or that they would never again see a staff member whom they were close to, that they would perhaps be placed in some place where they would be lonely. I suggest that through strengthening of peer support, through People First and perhaps otherwise, maybe some of that could be alleviated.

We need better information for systemic planning and advocacy, in our opinion. In preparing for this presentation, I went back and reviewed some of the reports that had been done, particularly around the five-year plan implemented by the Ministry of Community and Social Services beginning in about 1982. It involved five institutional closures, five institutions which were closed altogether, and two or three others which were significantly downsized. In looking at the reports, it was really quite disappointing to see that no matter who had authored

them, there was not too much information. They were the sorts of reports where the author had started with the conclusion and just included the information which seemed to support it. That is perhaps a little bit strong, but I do not think too strong.

There was a great deal of political pressure placed on various organizations during that period either to support or to oppose the plan. Consequently, I have put in a quote from an OACL report on the closure of Pine Ridge which indicates the ministry had done an excellent job, to an Ontario Public Service Employees Union report saying it is a disaster. I am not saying that the reports were badly done or that any of the information was not accurate, but I think all of these reports would have to be looked at very carefully to see if the whole picture was given.

In my experience, and admittedly I have only been in contact with a very small number of the individuals who are deinstitutionalized or their families, there is the whole range of outcomes. For some people, being placed in the community was a whole new life where you could hardly recognize the person the way they were before, and the families would support that, but other people were reinstitutionalized.

I think the ministry deserves some criticism for the fact that people were not followed up. So today, if we try to look at whether it was well done or badly done as a whole, I stand to be corrected if someone has this information, but I would doubt that anyone knows where the people who were in St Lawrence Regional Centre or Bluewater Centre for the Developmentally Handicapped are. I think it is only by looking at consequences 5 or 10 years down the road that you could really say whether it did work or it did not, hoping that the systemic function of the new advocacy commission will fill some of these needs in future.

Finally, I discuss funding—always a major problem—very briefly in the last section of the report. I will just mention a list of issues.

One is that in deinstitutionalization a major problem is transitional funding. When people are moved from an institution or in fact from any service, you cannot really reduce the funding proportionally. The idea is often expressed that the institutional dollar should follow the person to the community. If we are spending \$75,000 or \$80,000 on the individual in the institution, boy, we could provide a pretty good community service for that. The trouble is that if you downsize the institution, there are many fixed administrative costs, building costs and so on that do not drop that fast.

The Canadian Association for Community Living has developed a national proposal to deal with this issue which has been presented to the government of Canada, entitled the Community Living Resource Fund. If they are not presenting to this committee, I think at least that report should be looked at in terms of a national initiative to deal with this problem.

I also believe, having visited institutions and spoken to the staff, that there are many staff there who have accomplished a great deal with and for the residents despite the very difficult circumstances and that the skills they have should be brought into the community. Of course, in many

cases they are the only people the residents know and can provide some continuity.

I also would like to strongly support the special services at home program. I am quite familiar with it because I played a small role in advising on it when it was first established. It has accomplished a lot for parents whose children are at home, but I believe it is fair to say it has been badly underfunded, with the result I mentioned earlier, that people are saying: "Look, the government will pay \$30,000 or \$40,000 for my child to be in a group home. Can't there be \$10,000 or \$15,000 if we have our youngster at home?" Often the answer still seems to be no, the money goes to the established place. Part of that is due to the Canada assistance plan and is something that should be discussed with the federal government, because the cost-sharing dollars are triggered by the child's being placed in the care of the minister.

Individualized funding and brokerage, I believe, are new ideas but ones that should be looked at seriously, because they begin to address the ideal of the individualized program that meets the individual's needs. Unfortunately, these kinds of approaches are often associated with privatization and cost cutting, but I do not think that is a necessary connection. I think an alternative is to look at ways of employing people to provide services on a flexible basis so that they will have adequate salaries and adequate benefits.

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Finally, the broad initiatives of employment equity as it affects people with disabilities and social assistance reform have major implications for people labelled developmentally handicapped. There are now over 100,000 disabled people receiving the guaranteed annual income system for the disabled in Ontario. That is the disability part of the family benefits program, and their dependents are on the program as well; 22.3% have "developmental handicap" as a primary label.

Many of those people would like to work and I think it is important from a social perspective as well as in terms of the personal dignity of those individuals that we do everything we can to make sure that happens. We need to move towards a society where job coaching and modifications like, say, colour coding of what buttons have to be pushed are just as much a part of job modifications of the concept of employment equity as are ramps and adapted computers. I think we are moving towards that, but it is very important that some progress be made, because it should not be the case that developmental handicap automatically means a life on social assistance.

The final issue is one I personally have been involved with for several years. It is the problem faced by families who want to make a provision for their son or daughter in their estate. It is far from a simple issue, but I would argue that basically government has done very little, if anything, to facilitate this. I believe that a better policy is available which would look at some sharing of support between, say, a trust established by the family and social assistance.

There are some things that have been done in other countries in terms of specialized foundations or non-profit administrators of trust which may be looked at as models. I

have not had an opportunity to visit those places and review it in any detail, but I think to say to parents basically, "If you leave more than \$3,000 in a trust, we are going to review it and see if we can cut your son or daughter off family benefits, and that means the loss of drug and dental benefits too" to put that kind of disincentive in the way of people who basically want to provide support is quite a shortsighted policy, especially when there is such a shortfall of funding to provide even a minimal level of service.

That is only a very brief overview and I am happy to try to answer any questions that you have about it.

The Vice-Chair: We have, unfortunately, only seven minutes left for questions. Please keep that in mind.

Mr Malkowski: I just wanted to clarify to provide correct information. I have never been on the board of directors of ARCH. I have been a member, but not on the board of directors. However, you brought an important issue to our attention that we should consider. Can you make specific recommendations for this committee to think of in terms of the multi-year plans?

Mr Beatty: I have tried to outline some of those in the brief. I think I should emphasize one or two things. First of all, I think the forum, the way in which it was conducted and the participation of people who themselves have a developmental handicap, is absolutely critical. It is important to recognize those who carry around the label as active participants in the process.

That is not to say that the disabilities which many have are not significant and that their capacities to communicate are not limited, because they are, but I think it makes it all the more important to include them. Too often the debate proceeds with the people most directly affected not there and not taking part. I remember some years ago when I was with OACL, the ministry sponsored a conference at OACL that was called Why Can't I? and invited exactly one person, Peter Park of People First, to participate. Peter had some fun with the notion of "Why can't I?" I mean, basically, if I am not invited, I can't. I think you will hear more in the next presentation about that kind of difficulty in getting heard that consumers have had.

Mr Malkowski: Your report shows more than 100,000 people on permanent FBA are developmentally handicapped. Is it because of the label that they are on that permanent FBA?

Mr Beatty: About 23%, about another 25% have a psychiatric disability as the primary disability. Very often, once a person has the label of developmentally handicapped, yes, he does receive family benefits. I have been told by the Learning Disabilities Association that sometimes the people who have a learning disability are also labelled as developmentally handicapped. That is an indication they will get family benefits too. So the general model has been that if you are labelled developmentally handicapped, you get family benefits, but you do not get much priority or much consideration in terms of competitive employment.

Mrs McLeod: Of all the areas of interest and concern that your brief raises, I will try to focus on only two, with two very brief questions. The first relates to transitional

funding, which the previous presentation also mentioned, the importance of the transitional period. Do you have a sense that that is an area of concern that has been recognized? Is there a transitional fund that you are aware of? Has there been any chance to look at the program of the Canadian Association for Community Living?

Mr Beatty: I know it was presented to the Minister of National Health and Welfare, but I was not part of it and I am not aware of the detail. I think, however, it would be worth while for Ontario to look at their proposal as the starting point. I do have a copy with me. I could leave it with someone or get a copy made.

Mrs McLeod: My second question is in a whole other area. You make a note that a child labelled developmentally handicapped will not be allowed to attend school in some situations. Is it your sense that Bill 81 has been fairly effective in dealing with the appropriate placement of children with developmental handicaps or are there some real problems still there?

Mr Beatty: It is hard to generalize, because the response has been very different among boards. In some school boards, there has been a very positive response and an integrated placement will be available. In others, there has been a very considerable resistance. I think the legislation still leaves a lot of authority in the hands of the boards and it has been a very different picture from place to place.

Mrs McLeod: I will just ask, as a point of information, if the ministry could tell us whether there is any program in place for a five-year tracking as a monitoring evaluative device. It would be too early for us to have seen a report of that nature, but perhaps there is a process for that kind of evaluation in place.

The Vice-Chair: We have the ministry person present making note of that.

Mr Owens: My question is on the subject of abuse. Do you see the abuse detection and reporting protocols that are in place now as being effective and if not, why not, and what kind of recommendations could you make with respect to these protocols?

Mr Beatty: It is not a question that can really be answered briefly. There are certainly some ideas in our publication. It is very difficult, because many people labelled developmentally handicapped are vulnerable. They are not in a position where they have anyone to communicate a concern like that to. Even if they communicate the concern, they may not have anywhere to go to get away from the abuser.

I think over time one of the things the advocacy commission will have to look at is abuse. But there are so many things that have to be looked at, not just reporting but how these matters are handled by the criminal justice system and particularly what the alternatives are, so that if people come forward they are not at risk of being left in the environment where the abuser is.

The Vice-Chair: I am afraid we have run out of time. I would like to thank you for appearing before us.

1500

PEOPLE FIRST OF ONTARIO

The Vice-Chair: I would like to move right along to our 3 pm scheduled hearing for People First of Ontario, Norval Sears, who is the president, and Michael Callaghan, board member. Would you like to come forward, please. Might I ask that you identify yourselves, as I see that there are more than two people present. Welcome to the committee and, as I remind each of the presenters, you have half an hour and you may wish to allow yourself some time for questions at the end of your presentation. Please proceed.

Mr Sears: My name is Norval Sears, and I am the president of People First of Ontario.

Mr Callaghan: My name is Michael Callaghan and I am a member at large for People First of Ontario.

Ms McGill: My name is Judith McGill, and I am the adviser to People First of Ontario.

Mr Sears: I just wanted to say a little bit about the adviser's role. Judith has advised the board to help the board understand some issues and stuff that we do not understand, or if we sit on a committee or anything, she would help us to understand what the issues are. Some of us cannot keep up with issues too well.

People First has a board. They often label handicapped who have been in institutions, group homes, workshops or segregated schools. We do have a board to put in pride and we do our own business. They do not have anybody outside telling us what to do. We do it ourselves. Just to clarify, because we usually end up with somebody asking us if we run our own stuff or somebody else runs it for us, we run our own organization.

We have some big issues here that we thought are really of concern to us right now. What we want to see right now at this point is close down every institution in Ontario. It is not really right for these people to be in these institutions, because there are a lot of deaths in these institutions right now that were not known about. It has been around a lot of years.

We want to speed it up a little bit and we want to see these people who are dying in institutions out in the community, because they have a right. If they are stuck in an institution, they are dying in institutions right now. There were recorded deaths in Brantford, and Christopher Robin had so many deaths. I am not sure of the total, but I think it was 17 in Brantford at the last count, and Christopher Robin had 15 or 16 deaths. These are children who have never grown up to see what the world is really like. They died in these institutions. We want to have these institutions closed before anything else happens to these people.

I just visited with one institution, which Michael is going to be speaking on, where he used to live. What place is that?

Mr Callaghan: Huronia Regional Centre.

Mr Sears: Yes, we visited there. The human rights commission set that up and wanted us to go with them and take them through this institution. What we saw there is not a pretty sight for anybody to see. A lot of the corridors

are all locked up. They do not let their members walk around or nothing. They put restraints on their beds, they hold them down with restraints on their beds. It is terrible, and there is a terrible smell in this institution that they have to live in. They all are grouped into one room; they are not separate.

There is an unmarked grave in this institution, in which people have died. It does not have their names, who they are or which families they belong to or anything. They are unmarked because they do not have a name and it has been covered up too long. We need to know what is going on in these institutions.

That is why we want this institution to close down and give these guys a chance to live out in the community. A lot of them can live out in the community and they get support out in the community. We are not saying they will not need a lot of support; they will need a lot of support. We are not saying we are not going to give them support; we are going to give them support.

Just going on to talk about freedom for a minute here, freedom is when we can do our own things and we can do everything else. But right now, people in institutions cannot go to the bathroom or to anywhere in that whole institution without a staff member present. That is taking away freedom of a person who has to go to the bathroom and has to take a staff person to the bathroom. It is not really right.

In this institution they do have padded cells, like a cell. There are no doors on it, but it is padded one person who tries to hurt himself. They say these people are hurting themselves, but we have not even seen that happen. They said one guy would tear his flesh off, the skin, and he gets into violent rages. He never got into violent rages when we were there. He was calm enough to talk and he tried to talk to us, but he could not talk too long because he had a staff person there and he was scared to talk.

To talk a little bit more about this will be Michael. He will tell you what it has been like in an institution.

Mr Callaghan: Being in an institution is terrible. I was in one of them. I was in Huronia Regional Centre and it was like prison. I mean prison. It is just like a cell with bars all over the window. It is also not popular. It is not very good down there, no.

Interjection: How many years have you been in there?

Mr Callaghan: I have been in an institution for 17 years, and that is darned well long enough. They put me in, they would not let me go anywhere I wanted. If I was to go somewhere, they would have to keep an eye on us just in case we did something, and that is wrong. They drugged me too.

Ms McGill: Michael, who are "they"?

Mr Callaghan: The staff. Being in an institution is just like being blocked from freedom and that is not right. We all have to have our freedom sometimes. Freedom to do anything we need, to go to a show, to see the movies, to see a hockey game, to see a baseball game and go dancing, go to church and be with our girlfriends and with our parents, especially with girlfriends. We were segregated

from each other, separated instead of being together, which is usual.

1510

Ms McGill: Who was separated from you?

Mr Callaghan: My girlfriend, Suzanne.

I am living in Mississauga now in an apartment with my room-mate. He is doing okay. I used to live in a group home before that. It is not fair not having a girlfriend living with me. They should not do that. They should have me and my girlfriend living together, so I can take her to church every Sunday and go dancing and go to work and all that stuff. Being locked up is just like being isolated from freedom.

Ms McGill: Michael, where do you work now?

Mr Callaghan: I work in a nightclub, Superstars.

Ms McGill: Do you want to say anything else?

Mr Callaghan: That is all I have to say for now.

Mr Sears: You are probably thinking to yourself you can make up better rules than these institutions, but who is going to follow the rules? You can basically put rules in institutions, but no one is going to follow them. The staff are going to do what they want to do with these people. You do not know what is going on in these institutions. There are terrible things. You can basically, like I said, put the rules in effect, but no one will follow them, so you are just wasting time there. So we still want the institutions closed and bringing out all these people who could live in the community and have some support.

I just want to go on to the issues that we want dealt with. Michael is going to read them and I am going to answer them.

Mr Callaghan: People First of Ontario would like institutions to be closed as quickly as possible. The multi-year plan is painfully slow.

Mr Sears: As I was saying before, there is Brantwood and Christopher Robin. Brantwood has an inquest into the deaths. Christopher Robin does not; it just got a coroner's inquest. But we want an inquest in that death too, because a coroner's inquest could cover up a lot of what is happening to these people in this institution.

They have no right to say no because they are dead. They cannot speak on their own behalf or anything like that, so we are speaking on their behalf. We want that because the minister said there were four reported and the rest of them were not. It sounds like it was covered up, so we are asking just to think to put an inquest in both Brantwood and Christopher Robin and keep us informed as to what is happening in the institution because we have no authority to go in there to find out what is going on.

Ms McGill: Can I clarify something?

Mr Sears: Yes.

Ms McGill: Your comments there were for this second one.

Mr Sears: Yes.

Ms McGill: Maybe you could just read the second one, so that people know what recommendation that was

for, Michael, and then go on to number 3. So what you have just said really has a lot to do with this number 2.

Mr Callaghan: People First of Ontario would like a provincial inquest into all deaths in provincial residential institutions in Ontario, including provincially sponsored community residences.

Mr Sears: I kind of answered that question accidentally, so we will just go on.

Mr Callaghan: People First of Ontario would like a full inquest to be conducted into all of the deaths at the Brantwood and Christopher Robin institutions, that these inquests be carried out by community advocates and not by medical professionals only.

Mr Sears: The reason we want that part is, right now I guess the minister has three nurses looking into or inquiring into these deaths. They are part of the government, in a way. They will probably just say they died of natural causes and they will not come out with the very truth, but if we have one of People First's members in there to talk to these people, who can be able to communicate with them, now we just need an advocate to go in there and tell us what is really going on and not to cover this whole mess up, like it tends to be covered up all the time.

Mr Callaghan: People First of Ontario would like better external monitoring of conditions in residential facilities, including more effective reporting of deaths and causes, having a way for residents and families to report abuses without worrying about further abuse, and full authorized access to institutions by People First members.

Mr Sears: The reason we said that was, we need at least one of our members or people who have to do with People First or the local group to go in and talk to these people, because right now, if they have staff around them—I have seen this happen many times—staff will be in the room and then the people will not say what they wanted to say. Let's go back to the one I just visited, the institution. One person opened up to me because there was no staff around and he was just telling me he had been in an institution. He is 75 years old now and he saw his own brother and sister die the first day they went into that institution, and he opened up. There was no staff around at that point, so that is what we are trying to say: if they can communicate with us, we can communicate with them without staff telling them what to say. Staff could make them say anything they want to say and then we will not get near the truth of what is really going on in those institutions.

Mr Callaghan: People First of Ontario would like commitment to the idea of ensuring that the advocacy commission remains independent with strong powers for monitoring abuses in community and institutional settings.

Mr Sears: That one speaks for itself. Right now, there is not much that I could say about that one.

Mr Callaghan: People First of Ontario would like a policy of no further admissions to provincial institutions and that people at risk of institutionalization or readmittance be given top priority for community services.

Mr Sears: We want the institutions closed, but from the minister's point of view when we talked to her, it sounds like she wants to admit more people to the institutions. Instead of closing them down, she wants to keep them open. But we want them closed. I am just going back to the deaths. There are too many deaths which are occurring. People have got to live their own lives. They have their rights, but they are taking away theirs right from them.

Mr Callaghan: People First of Ontario would like closure of all homes for special care and boarding homes and rest homes that are allowed to make a profit out of exploiting helpless people and treating them poorly.

1520

Mr Sears: I want to make a comment for that part, that people in these residents and group homes and that, the staff gets more money than the people they are serving. So you get the money, but the staff is getting the money just to support them and work with them and that, but it should be the other way around. It should be the people in these institutions and these nursing homes who should get the money, not the staff.

Mr Callaghan: People First of Ontario would like the Lightman inquiry into unregulated residential facilities in Ontario to include self-advocates who have had to live in these facilities, as well as to consult extensively with People First of Ontario.

Mr Sears: What we are asking right there is to be consulted. We have not been consulted with any inquests or anything. We have been hearing this by an airwave situation and we get it piece by piece, but we want to be consulted as to what is going on so that we can help our own members to understand. We need that consulting so that we can do something for them.

Mr Callaghan: People First of Ontario would like to participate in the forum that has been called by the Ministry of Community and Social Services and have a say in the way this is structured so that we can participate in a meaningful way.

Mr Sears: This one here, it was just mainly saying that the mentally handicapped want to have a say in what is going on. We are not having our say in what is going on in these inquiries. You have to go through a lawyer right now. We would have to if we wanted to ask a witness or something like that, but we want to do it ourselves. So we want to have our say in these inquests into these deaths. These are our people who are dying in these institutions, so we should be able to have our say in these.

Mr Callaghan: People First of Ontario would like to be consulted about which community service options are the most supportive of the needs of people labelled mentally handicapped so that people will live in homes, not services.

Mr Sears: That speaks for itself. That is the end of our thing, if you have any questions.

The Vice-Chair: Okay, we have seven minutes left for questions. I would like to divide that time up evenly among the three parties. Mr Malkowski is on the list first.

Mr Malkowski: I think we should be allowed to add extra time. I think you should maybe give them 10 minutes, give them extra time, because the presentation was slow and we want to be fair to them.

The Vice-Chair: Okay. We can certainly do that. I can probably go on a little longer, but I still have the three questions, one from each party.

Mr Malkowski: Okay. Thank you, Mr Chairman. I was very impressed with your presentation. I was very struck by the information and how it will be helpful to us, providing your firsthand experience. Do you feel it is very important for people who are in the institutions to have the right to get information related to their rights about reporting sexual and physical abuse, that the people in the institutions should be informed of their rights, and then that allows them the choice that they could move out of the institutions?

Mr Sears: Yes.

Mr Malkowski: Do you feel that is important as a recommendation?

Mr Sears: Yes.

Mr Malkowski: I know that consumer groups and parents both have very strong and often different opinions. Some parents want to put their children in institutions and keep them there. Often that conflicts with the consumer's option. Do you feel we need to consider the recommendation to protect the rights of children who are under the age of 18?

Mr Callaghan: Yes.

Ms McGill: Can I ask Michael a question for clarification? Mr Malkowski asked you whether or not people who are not yet 18 should stay in institutions. Is that fair?

Mr Callaghan: No, it is not fair.

Mr Malkowski: Do you think we need to set up protection for those people who are under the age of 18 who want to move out of institutions but their parents do not want them to? Should we provide some kind of protection for them?

Mr Callaghan: Why not? That is a great idea.

Mr Jackson: I want to thank you for an excellent presentation. I have listened to Pat Worth's presentation on several occasions. You are doing as good if not a better job as Pat ever did, so I wanted you to know I am very impressed. I want you to know that Marilyn Heintz is a close friend of mine and I work closely with her, as she is a full board member in our association of community living in Burlington. I know you have met Marilyn Heintz before. I am very proud of her work.

I want to thank you for focusing on an issue that none wants to talk about at these hearings, and that was the situation at Brantwood and Christopher Robin. I want you to also know that you are the first people to really raise this issue for us. I want to share with you that I certainly agree with you that a full inquiry is required and want you to know that when I asked the government if it would have a full inquiry, would it do so because of the reasons you have raised, it indicated it did not feel it was necessary at this time. However, for

years ago when this was happening in a nursing home for senior citizens and they were dying, they were asking for a full public inquiry.

Do you feel that is discrimination, that there is one level of concern for a full public inquiry when senior citizens were dying but when developmentally disabled children in institutions were dying we do not have the same standard? Do you consider that discrimination against you?

Mr Callaghan: Yes.

Mr Jackson: Norval, do you want to expand on that, because no one is talking about this aspect of your brief. It may not be discussed again unless we talk to you about it.

Mr Sears: Do you want to repeat the question?

Mr Jackson: It has to do with the fact that you know that the government is unwilling or will not allow a full inquiry so that your association can go in and advocate, to consult, to listen to the residents who are living there to discuss the terms and conditions. In fact, Marilyn Heintz said to me her concern was that the person appointed by the government is a nurse and a member of a union, and the persons they are partially investigating are members of a similar union. Those are the kinds of concerns Marilyn shared with me. You have hit that point here, both of you, and I just wondered if you agree that perhaps the nature of the current inquest was inappropriate and that you want standing before some larger inquest so that you can be present, ask questions, listen and make sure the residents' concerns are being discussed.

Mr Callaghan: Yes.

1530

Mr Sears: Just to expand on that a little bit, why People First want to be at this inquest is so that we can be heard. We are advocates. We advocate on behalf of other people who cannot talk for themselves. That is why we want to be involved with this inquest, so that these people will understand that we went there and got their issues across about what happened to them in institutions. So that is our way, it is advocacy to help every one of us in nursing homes and everybody who is dying in the communities. I am not just segregating the institutions. It is all over that needs to be overhauled.

Mrs McLeod: I also wanted to thank you for doing an excellent job of telling us your story today. I wanted to ask Michael another question or two. You told us what it was like to be in an institution and what that felt like, but I would like to know a little bit more about what it was like to go into the group home. Was that a good place to be? Was it easy to move in?

Mr Callaghan: It was.

Mrs McLeod: So you had no problems when you went into the group home.

Mr Callaghan: No problems at all.

Mrs McLeod: Is it okay in the apartment now? Is it okay getting to work and managing on your own?

Mr Callaghan: Yes, it is.

Mrs McLeod: Congratulations, Michael. That is great to hear.

Ms McGill: Could you maybe explain to Mrs McLeod who made the decisions about your leaving the institution, how much say you had, or what would you have liked to have done when you left the institution?

Mr Callaghan: Staff made the decision that I move out of the institution.

Ms McGill: Who decided that you would move to Port Credit?

Mr Callaghan: The staff.

Ms McGill: Where would you have rather moved to?

Mr Callaghan: Hamilton.

Ms McGill: Can you tell them why?

Mr Callaghan: Because my girlfriend is there now.

Ms McGill: Did she leave the institution at the same time you did?

Mr Callaghan: No.

Mrs McLeod: Did anybody ask where you wanted to go?

Mr Callaghan: No.

Ms McGill: You said earlier that you would like your girlfriend to live with you now.

Mr Callaghan: Yes.

Ms McGill: Why is that a problem?

Mr Callaghan: Because they do not believe that we have a good relationship together.

Ms McGill: Who are "they"?

Mr Callaghan: Staff in Hamilton.

The Vice-Chair: I would like to thank you for your presentation. Unfortunately, we have run out of time and we have a very, very tight schedule. Only so much time was allocated so I have to move on. Before we do that, I think it is appropriate to have a few minutes' recess. It was requested. We have been going two hours straight here and I think everyone needs a brief recess.

The committee recessed at 1534.

1544

PARENTS FOR COMMUNITY LIVING

The Vice-Chair: I would call upon the Parents for Community Living, Joye Krauel, Allison O'Farrell and Keith Heimpel. Welcome to the committee. As I remind each of the presenters, you have half an hour. You may divide that in whatever way you deem appropriate.

Mrs Krauel: Perhaps I could just introduce us. I am Joye Krauel, this is Allison O'Farrell and this is Keith Heimpel.

Mrs O'Farrell: We are from Parents for Community Living, Kitchener-Waterloo. First we will tell you who we are and our history. Parents for Community Living is comprised of a number of families who have one or more family members or friends who, because of a developmental handicap, require support to live fulfilling lives in the community. Our goal is to provide homes. At present, 20 such families form the core of our organization, which has

over 100 members who support us in our vision of a community where everyone belongs.

Our vision: We envision "home" to be family-sized, comfortable, nurturing, responsive to the strengths and needs of those who live there and supported by a Christian environment. Support persons will live in the home and work together to respond to the needs within the home. Each home will be developed in partnership with a faith community, and our hope is that every faith community will in time become involved in the lives of persons who have a developmental handicap.

We believe adults with disabilities need to have a life of their own, involved with their families but not necessarily living with them. We seek a quality and direction to their lives that is based on belonging, acceptance and welcome in the community.

We want to build a community of support which will secure the future for our family members and friends, a community which allows them to have fulfilling and interdependent relationships with their families and friends. They need support in a home and they will also have a great need for continuity in relationships. Their families need the assurance that a caring community will provide this continuity.

Sons and daughters who are adults should be recognized as such. Therefore, they need to live in homes with people with whom they relate, whom they respect and with whom they are compatible. They need to live in households where they have some control over the decisions made, some voice, equitable responsibility consistent with their ability and where they have the status of ownership. There are many ways to achieve ownership, but fundamentally, it is to mean that the home is their home.

We will develop a support network to ensure continuity of responsibility over time. It is important that persons from the community freely choose to become involved to the point that they develop a commitment. This support network of friends will encourage active participation in faith community and community life.

An incorporated board of directors will have ultimate responsibility for the homes. However, each home will have a house council comprised of the support couple, the individuals in the home and an advocate for each individual representative from the faith community, support networks, Parents for Community Living and the board. This council will be concerned with the quality of daily life within the home, will help to ensure that the home remains true to the philosophy and will also act as a liaison with the support network and the faith community.

Mr Heimpel: I would like to give you a little background on Parents for Community Living, how we came into being, because I think it is important to get that context, from where we are coming. About six years ago, several parents came together because we had mutual concerns for the wellbeing of our adult sons and daughters. Within a year, a core group of parents were meeting on a regular basis with the help of a facilitator, Father Pat Machan, who is a resurrectionist priest centred in Waterloo and who did a lot of work internationally but largely across Canada.

Under Father Pat's guidance we began to develop our community work. We told our stories to several church communities and asked them to consider working with us. Our stories would be the story of what it was like to have a handicapped family member and to keep that family member in our homes with us. St Francis parish in Kitchener invited us to submit a proposal and so began our plans for our first home.

In October of 1988, we incorporated a board of directors, purchased a home at 48 Blueridge, right across the street from St Francis parish, and secured a mortgage on the home through the signatures of a number of our parents and friends. With a donation from St Francis parish, we began renovations to the home to make it wheelchair-accessible. In February 1989 Douglas and Tom moved into their new home, and with the completion of added renovations in June the same year, Joseph joined them.

1550

Everyone in PCL participates however she or he is able to. We do not have government funding, so it is a real struggle to continue to raise funds to pay the mortgage interest and to assist the men in paying the operating costs of the home. We know that our service is very cost-effective. We know it is unique in its person-centred vision and in its depth of community involvement. However, the fact is we will not be able to proceed further on tenacity and faith alone; we need assurance of operating funding, and fairly soon.

We are currently in second-stage funding approval for a Ministry of Housing grant for this home and also for the purchase of a second home. Final approval is anticipated for April 1991, all things going well, and we will hope, of course, that operating funds will follow with the support of the Ministry of Community and Social Services. Assuming all goes well again, four persons will move into home number two in the fall of 1991 in partnership with Trinity United Church in Kitchener.

I would like to talk a bit about our observations about the multi-year plan. We formed Parents for Community Living to ensure that our family members and friends would not be placed at risk of institutionalization. We are in complete agreement with Challenges and Opportunities where it is stated that "The institutional system is not considered a viable model for the future." We believe strongly that everyone belongs in the community—I would like to emphasize that—and that those persons who have been excluded from community living must be returned to the community.

But in order for that to happen, a lot of other things have to be put in place. It certainly does not make sense to us to place persons already in the community at risk due to lack of proper housing, employment opportunities and support services and at the same time bring individuals out of institutions. To make the closure of institutions a reality persons living in the community already must also be served there. Many of our families in the community already meeting needs of very challenging individuals. A lot of the challenging individuals in the province of Ontario do not live in institutions. So we need supports on both sides of the equation.

Special services at home is an example of a program which offers an individualized approach to support for families. However, families often find this program inflexible and deficient with regard to the number of hours and, in some cases, the types of services it will provide. For instance, with regard to serving adults, the type of support extended is very limited and consequently may not respond to the needs of individuals. If this service is truly meant to support families in keeping their family members at home, families have to be listened to. The needs of their sons and daughters have to be addressed. Families do not have the time or energy to constantly be renewing contracts and/or really not having the assurance of ongoing funding under that program.

Existing waiting lists indicate clearly the need for housing options, particularly for adults. Many of the parents in our group have sons and daughters who have lived with them for 30 years or more, and they have no peace of mind with regard to the future of their family member. Indeed, it is this very reason why Parents for Community Living came into being.

Again, employment opportunities in our community are also very limited. New initiatives in employment are badly needed. In fact, for the first time in over 30 years, K-W Habilitation Services, which is the major service provider in our area, has established a waiting list for all of its training and developmental programs for adults. Our daughter, Jennifer, like many other young handicapped people, graduated from high school to nothing. There is nothing there for her. Unless, as in our case, families have the resources to put their own dollars behind the purchase of a supportive worker, there is nothing for them at all. Even post-secondary school education is not an option in our community if in-school supports are required.

Funding for job coaches is badly needed. Persons with challenging needs have a right to a range of options in employment. Not everyone wants to or indeed can work in a sheltered workshop setting. Very few of the intentions noted on page 28 of Challenges and Opportunities have been initiated. We would encourage this government to do what it can to open opportunities.

In order to meet the needs in each of the above areas, we must have more flexible services and funding arrangements that are tailored to each person's individual needs, an objective also stated in Challenges and Opportunities. Services provided should respond to the needs of an individual and should not be linked to where a person lives. They ought to be totally portable. Again, Challenges and Opportunities talks about doing exactly that thing.

Mrs Krauel: We are certainly in agreement with phasing down the institutions. Our philosophy is to build around individuals, to get to know them well, their strengths and their needs. Each person living in a Parents for Community Living home has a circle of support. This is built up by the families themselves and consists of a family member, friends of the family, people from the community and also from the faith communities. We consider this network of support essential in order to provide advocacy and the assurance of real involvement in the community. Parents and friends play an important role in

the development of circles. If we provide homes for individuals from institutions, it is quite likely that there will not be a family network. As I mentioned, this circle of friends is usually built up by the family, so we would need funding to provide a co-ordinator-community developer to provide this service.

We feel that anyone living in an institution or a nursing home should be considered for community placement. For instance, we would like to be able to consider individuals living in Sunbeam Home, which is our local institution in Kitchener, for placement in our homes, but we have been informed that extra funding would not follow these persons and we desperately need that funding.

It is essential that a person returning to the community has a day program and/or extra dollars to provide for any special needs. At present, there are no day programs or employment openings. Pete mentioned that there are no spots at the K-W Rehabilitation Services any more for employment for community persons, let alone anyone returning from institutions. Obviously this deficiency has to be addressed, and very quickly.

People with very complicated needs are already living in the community, not just in institutions. We have two families in our group alone who have sons who are 30. They have kept them home all these years. Neither of them is toilet-trained. They have to wear a helmet because they have seizures and they fall. They have kept them at home all these years, so they are not just all in institutions. We need to enrich supports for them. If these supports are in place, the community will be already prepared to respond to the needs of persons returning to the community. We would not like to see the development of a continuum of special services, but rather the services that are already in place in the community should be enhanced.

For example, we have in our community a community resource team which is mandated to assist families who have a member with a developmental handicap or individuals living away from their families. This team provides an excellent service that may well need to be enriched. Also, we feel that community support workers should be available to persons living both at home and away from home, not just in independent living situations.

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As well, at the moment we have a small, pilot, integrated employment program operating in conjunction with the Association for Community Living and the Centre for Research and Education in Human Services. They may have some very valuable experiences to share with regard to the integrated employment. At the very moment, they are working with my son to get him a job in the community because we are hoping that some day he can work there and be treated a little more humanely.

A major concern for us is the indicator from government that numbers of individuals sharing a home must be increased from three to six. We take strong exception to the wisdom of this move. The successful integration of persons with special needs is very dependent upon their ability to adapt to the community and to the community's acceptance of their presence. If they are in large residences, the community will simply see them again as

small institutions. It is critical that barriers are not placed in their way to be accepted. The ability of persons to live together in harmony is contingent upon numbers to a great extent. Small homes are both more appropriate for residents and more acceptable to the community.

In summary, we support community living for everyone. We have identified the following as barriers to the achievement of this goal: the lack of flexible funding and the portability of funding; the lack of more homes and a range of living options; the lack of employment opportunities and options for employment; the lack of funding for job coaches. This is what so many of the community jobs depend upon. They are ready to take one of our people as long as they have a job coach with them.

We are concerned about the lack of creative day programs; the lack of support for innovative projects; the lack of opportunities for post-secondary education; the lack of emphasis on relationship building and networking to ensure inclusion in community life.

We certainly appreciate the opportunity to come here today and give you our opinions and our concerns. If we can answer any questions, we would be glad to.

Mr Malkowski: I am very impressed with what you have given us this afternoon. I think it is really important for this committee to consider specific recommendations that would assist us during our deliberations. I am wondering if you agree with the concept that institutions should be closed or should be made available to individuals as options.

Mrs Krauel: I think we are all in agreement that they should be closed.

Mr Heimpel: Yes, no question about it.

Mrs Krauel: No question about that.

Mr Heimpel: It is not the right place for people to live.

Mr Malkowski: That is fine. I think it is very important to provide more resources for parents, because often they do not know what their options are and they end up putting their children in institutions. Resources information is not being made available to them. I think this would certainly help them in making a decision not to put their children in institutions.

Mr Heimpel: I agree. I think one of the problems in Ontario is that we seem to be going the route of a little bit in the community, but institutional models staying in place. I think it is a mistake because it is dividing the use of scarce resources. I am afraid the institutions are gobbling up a major share of that valuable resource. I think it is better to follow the example of some of the other provinces that are closing institutions altogether. It is not the right place for people to live.

Mr Beer: One brief question: On the concern you indicate that the number of individuals sharing a home must be increased from three to six, I am just wondering when that began and whether you know is that because of financial issues or is it that people felt it was more important to have that grouping.

Then if I could, there is your point about the lack of flexible funding and portability of funding. What would you like to see here, that the money would go with the family or with the individual, and that is the way you would determine what would be done as opposed to going to an agency? What sort of correction do you want there?

Mrs Krauel: Could I answer the last part first? I am going to let Keith answer the first part.

I am going to be very personal. My son is 30 and he now has, as I said, the opportunity to work out in the community. Unfortunately, he cannot use the bus at this point in time. When we have tried to teach him, he has thought of it as a game, so he gets lost and he thinks it is great fun. We have applied for the adult services now to give us some funding for bus training. We have been told, fine, we can have the money, but we may not use it for him at the time that he is going to work.

Now, this is ridiculous. If we train him in the middle of the afternoon or in the evening, there is none of these mobs of buses, with six or seven buses coming up to one bus stop, which we have in Kitchener-Waterloo, and this is where he becomes confused. I personally have been agitating and I finally have got our local transit to turn that—I do not know what you would call it, but that little thing at the front; I am sure you have it everywhere. They were not turning that sometimes until they were driving away and this was very confusing for our people. They have now promised to do that.

The point is that if my son Blair is trained in the middle of the afternoon there is not going to be a problem. Only one bus will pull up to that stop and he will get on and be fine. Where he needs the training is at the actual hours that he is going on the bus, but they have said that unless I accept the funding the way it is, there is no funding.

Mr Heimpel: I think on the affordability issue we are often told that because Blair might move into a home away from home, the funding stops altogether because he is not living at home any more. That is what I mean by affordability. He needs that support just as much as he did at home. Why stop it? That may not be a good example. Once Blair knows how to use the transportation system, he maybe does not need that funding any more, but there are lots of other good examples where the funding is required almost on an ongoing basis. That is a barrier against independent living.

On the issue of the number of people living in a home, when we began talking to the Ministry of Community and Social Services about a second home, where we got indications of a housing grant for a second home we were told, "Three is out, six is in." We feel quite pressured to get away from small is better to the larger because of costs. We are told resources are not available to accommodate homes with three any more.

I think that is a mistake, because we ought to be looking at the quality of life for all of these people and confusing it with greater numbers is putting that quality issue at risk; it really is. It is not the right thing to do. Besides, I think the community has expressed itself well

n that regard. When the house next door is filled up with six persons plus support people, with cars in the driveway, all over the place and so on, it is not a good thing to do. We want the community to be accepting, and on the other hand we do these things that tear it down. So both reasons are quite valid. Please do not do that to us. Do not make us take that quality away.

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Mr Jackson: Let me say first that Elizabeth Witmer, who is a regular member of this committee, had to leave for a funeral in her riding or she would have been present today, but she has briefed our caucus at least with respect to your concerns and has shared them personally with me. I am the critic, and she sends her best wishes.

Thank you for your presentation. There are a couple of elements I want to focus in on very quickly. First of all, Keith, who is it who is specifically communicating to you the move from three to six residents? I am not catching his.

Mr Heimpel: The local Ministry of Community and Social Services office, the Waterloo regional office.

Mr Jackson: Do they share that with you in the form of a memo or is it a ministry directive?

Mr Heimpel: No. It is verbal, but it is indicated as a ministry directive.

Mr Jackson: Can you share with us who the individual at that office is. I want to get to the bottom of that.

Mr Heimpel: The deputy minister was in town a couple of weeks before Christmas and that is when it was made a lot more official than it was in the previous telephone conversation, but the rumbles had already started even in November.

Mr Jackson: Have you had any discussions? I know of situations where we have four, where we have sufficient bedrooms. I have worked in my own community for these homes. We have acquired several and we draw the line at four. If we get a fifth bedroom, it is an extra bedroom if a family member wishes to stay, but not for respite. Are they suggesting that you start at six and negotiate down to four? We know that is a game that is played.

Mr Heimpel: It could be. We have told them we think we can manage with four.

Mr Jackson: Have you heard anything from the municipality? I know we worked for two years to eliminate exclusionary bylaws in this province and Kitchener was one of the target communities that was discriminating actively against groups, trying to categorize them as group homes and impeding them. It strikes me that runs counter to the spirit, by starting to increase the numbers. You are really referencing that a community backlash might be what happens as a result of the ministry pushing you in this direction. They are contributing to bad relations within the community at the very time when relations need to be improved.

Mrs Krauel: That is right.

Mr Heimpel: I agree. It is kind of against the spirit.

Mr Jackson: My final question—and thank you because there is a lot I wanted to cover with you—is on continuing education program access. This is a big bugbear for me. We have heard many presentations about that is it for a student at age 21. In fact we have evidence that at age 20 they are cut off. It strikes me that we are seeing sort of a perverse set of priorities from school boards and others in terms of we will partially fund advanced bridge for adults as continuing education and adult education in our schools, but we do not have the commitment nor the linkage in order for the education system to do follow-up life skills, which is really the vehicle that would be helpful for your son.

Mrs Krauel: It certainly would.

Mr Jackson: The school could operate those programs at varying times. I notice we are doing it for seniors, for activation following strokes. There are some great pilot projects around the province. But it seems to me the school boards are not helping us to find an agenda for this group of citizens. We have grandparent linkage programs for older people, but it seems that this community is just—we are glad that is over with for them and that is the end of it.

Just briefly, have you had any discussions with the school board about shifting some of its priorities for programs so that it can embrace them? The legislation does not prohibit it. The trustees have the right and ability to move in that direction. Have you any comments on that or any discussions with the Kitchener-Waterloo board?

Mr Heimpel: I am on the K-W association's committee for post-secondary school opportunities. I think we are really talking about the community colleges here. I think the school boards—Ottawa let them off the hook totally—are doing what they can. I think they are being fairly flexible too in our area, the separate school board especially. It is the community colleges that are closing the doors to our people. They have some supports available, but the problem becomes when you need a support person to help get around the campus of the college. Do you have to pay tuition for the support person as well? They are saying yes right now and they are not very willing to even work with us on a pilot project to let us show them how we think we could maybe get together and make the program work. Of course, they are citing the lack of funds to do this, etc.

Mr Jackson: That is very helpful.

The Vice-Chair: I am sorry. We have run out of time. I would like to thank you for your presentation. We must move on. I am pressed. We have two other groups appearing before us.

FEDERATION OF ONTARIO FACILITY LIAISON GROUPS

The Vice-Chair: I call on the Federation of Ontario Facility Liaison Groups. There are a number of you from that group, so I will ask you to introduce yourselves and make your presentation. I remind you, as I do all of the groups, that you have half an hour and we have to stick to that time limit. You can divide that half-hour in whatever way you deem appropriate.

Mrs Paproski: We appreciate the opportunity to come here. I am Margaret Paproski, president of the Federation of Ontario Facility Liaison Groups. Archie Leduc is our treasurer; Stuart Mussells our vice-president, and Dr Alan Bruce-Robertson another member.

The Vice-Chair: I just mention to members of the committee that we have a package that was made available by Dr Bruce-Robertson. Our research officer has it available for your use. It is filed with her. Please proceed.

Mrs Paproski: There is also a package which was faxed from me last Thursday which you should have received. I thought what I would do would be to speak to the highlights on the second page, not go through the document itself. It was pulled together very quickly on Thursday when we found out we had the opportunity to attend.

I would just like to further state that we are all volunteers, that we have no paid assistants or such. We come from a wide area of the province, representing facilities at Thunder Bay; I myself Rideau Regional Centre, Smiths Falls; Archie Leduc is with Oxford Regional Centre; the other two with Huronia Regional Centre. We also have a representative here with us from Southwestern Regional Centre and other representatives from Prince Edward Heights, and we also have somebody from Muskoka Centre as well. We represent, in total, eight different facilities.

We started our organizations when the facilities began to operate as parent support groups. Today they would be called advocates. In about 1982 we felt that the needs of severely, profoundly multihandicapped people were not being addressed by what is now called the Ontario Association for Community Living. We are also, most of us, members of that association and many of us have spent many hours in developing community programs. We are fully in support of community programs for people whom we feel benefit from them.

We must, however, address the issue of the severely, profoundly mentally retarded person who may have other handicaps and who is aging. In the institutions today, at Rideau Regional Centre, for instance, the average age is 35. At southwestern, out of a population of 600, only a few are under the age of 35. So their skills are declining.

The federation had established a subcommittee to work with the ministry last year, to tour community facilities and see what was developing in group homes, workshops, etc. We have visited two group homes in Ottawa. Each one cost over \$300,000 to acquire and to furnish. They accommodate four to five residents and have 24-hour staff. During the daytime there are three counsellors, plus administration costs. We are looking at a very, very high per diem rate.

We have to be realists. We have faced up to the fact that our children are handicapped. They have acquired a number of skills, but they are never, ever going to be employable, not the majority of those who currently live within the institutions.

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Also, with these particular group homes I visited, the agency which started up those homes is now starting to go into deficit budgeting. We do not think the multi-year plan

has been well thought out in terms of the total cost if we are to provide equal, universal services throughout this province for people with handicaps. In fact, it will develop privileged services for a few. Others will receive below-average services and others in desperation will receive none.

The budgets, also under this multi-year plan, are being squeezed at the institutions and having adverse effects. For instance, at Rideau Regional Centre we have been without a speech therapist for two years. We are now in the position where we have some residents who have, with great difficulty and great work acquired skills in communications using the Bliss symbols or sign language, and they have counsellors who cannot use those communication skills. Can you imagine the frustration after many years of developing a system of communicating and now being in the position where your counsellor cannot communicate with you? We are losing some of our best counsellors, the well-trained counsellors, because they have to look for their own young families, their own career opportunities and therefore if there is a chance for them to get into the community to work, that is where they are going.

I would like now to go into an area which we feel very strongly about. The very specialized needs of the aging severely, profoundly multiply handicapped adults have not been addressed. It has been estimated that the residents within facilities require five to six times the medical care of the average population. Many of them have limited community skills, so they are very vulnerable and they need protection and security. The institutional service can provide that.

My daughter, for instance, has been lost, on a short basis, for 20 minutes. Immediately the search and rescue squads are called out. She functions at a two or three level intellectually, communicates at maybe a six-month level. She was found. Immediately, the doctor is there to investigate to see if there has been any problem, and there is the support to help her get back into her little milieu and feel the security of her friends.

What is not recognized is that the institutions are home. They are home to some people who have lived there for 30 or 35 years, yet under the multi-year plan it is proposed that these people who have lived in this home are to be discharged. To where? To foreign communities where they have no friends? In an institution they have the opportunity to make friends from a wide group of people. They can develop supportive relationships based on affection and similar interests. They have an opportunity to give and take, help one another and therefore build up their self-esteem. They belong and feel accepted there. It operates as a small community.

There is a variety of activities which can take place without transportation problems, without having to brave the elements of the snow or the rain and all these other things that are especially difficult for physically handicapped people. There are developmental programs, adult education, work opportunities, recreation, swimming sports, concerts, dances, parties. They have a choice of whether to attend these or not. They can walk down the hall and hear a great party going on and say, "Hey, I want

to go in for 15 minutes," and then it becomes too much for them, the stimulation is too great. They have the opportunity then to go back into their private quarters to calm down. They have choices.

They also have choices to go into the community. I must say that the \$100 per month they are receiving has enabled them to do this much more. They are going to ball games, hockey games, going out to church functions, to concerts, on small trips. Certainly from Rideau Regional Centre they have come down to Canada's Wonderland. They are able to get out, maybe to go to a restaurant with a couple of friends who support them. In fact, it is easier: My daughter will go with a counsellor and a couple of other residents into a restaurant much more easily than she will with us. She is happy with the group she is with.

I had the opportunity of keeping my daughter at home until she was 11, and I saw what the community did to her. They rejected her. As she got older it became even more so, because she became more strange looking to them. She was aware of that and she withdrew, to the point where I could barely get her out of her bedroom. Now that she has received self-confidence within the institutional setting, where she knows she can do some things well and she can assist in certain things, she is more forthright, outgoing, happy to be involved in things. She has that security, she has that supportive environment.

Also, within the institution they are challenged to improve and to develop, but with professionally trained staff and support staff the stress and anxiety levels can be kept within normal limits. Too often in the community we have seen people who are developmentally handicapped ending up in psychiatric wards because they cannot take the stress of normal life. As I mentioned, within the institution they have tremendous freedom to walk down a hall and think they are not supervised, yet in fact somebody is keeping an eye on them when they need to.

However, under this multi-year plan we do have some very grave concerns about the institutional life. It was 10 years ago developing a more normalized environment for all its residents. Wards were being developed into apartment settings and day programs were being developed. People were being treated as individuals. This budget squeeze is now being placed on the institutions themselves. As the population declines, instead of using the extra space to develop an environment of maybe six people within a ward, make it into a bungalow-type setting, they are closing those areas or, for instance, in Huronia I believe the Ontario Provincial Police is using some of the excess space. Many of our residents are being placed into inacceptably overcrowded wards where they have no privacy, no opportunity to keep their own things. This multi-year plan, because it has not addressed the cost of caring for people either in the community or in the institution, is adversely affecting the quality of life in the institution.

On the other hand, we have some very good institutions and we really would like an answer to the question we have asked many a time. Midwestern, outside Palmerston, is a beautiful little institution where they do have apartment-like settings, yet it is slated for closure in 1994, while another one which is not as modern, does not pro-

vide as high a quality of life, is to remain open. Muskoka: a beautiful piece of property, marvellous opportunities to develop a good quality of life for people who need a supportive environment. It is slated for closure. We must question the rationale of the multi-year plan. In whose interest is it being implemented? In our opinion, not in the interests of profoundly mentally retarded adults, especially those who have additional handicaps and who have limited communications skills.

The federation, contrary to probably all the submissions or the majority of submissions you have heard today and yesterday, strongly supports congregate care as an option. A very important aspect of quality of life is choice. We believe that choice should be there, just the way that choice is available for senior citizens who opt to move into a retirement home or people who join the armed forces, who have a very specialized community. You can see it today with the men going to war, how those communities band together to support each other. We think developmentally handicapped people should not be denied that choice.

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The last thing I would like to address is that we have called time and time again for cost projections of community services and institutional care. We have not yet seen any valid or any comprehensive cost projections for this multi-year plan.

I would like to thank you for this opportunity, and we would welcome any questions you may have.

Mr Malkowski: Thank you for your presentation. What we heard so far this afternoon from two different groups, People First and then the parents of disabled people, is that they both are very strongly in support of closing the institutions and transferring those people into community living. So it is interesting to hear your perspective about that situation. Would you support their opinion? What are your feelings in terms of closing the institutions?

Mrs Paproski: We would like to see that option remain open. We do believe there should be improvements and that the style of life should be more normalized, that people should not be congregated into large open wards. But there is an opportunity to develop that community, which I think would be very supportive and should be an option, just an option.

Mr Malkowski: On page 3 of your presentation, you say you support the transfer from the institution to the community if all the support services are available. Can you clarify what you would look at as criteria for "all support services?"

Mrs Paproski: Support services within the institutions provide medical, psychiatric, psychological, physiotherapy, speech therapy, developmental training, teaching, social and recreational supports and dental care by people who know how to work with residents who are handicapped. I am going to let Dr Bruce-Robertson respond to this a little further, because he has a greater awareness of some of the conditions of the people.

Dr Bruce-Robertson: The quality of services is so high in the institutions that we reckon it is going to be

very hard in most cases to duplicate them in the community, certainly when they are scattered around. Contrary to what you have heard from some people, none of you is taking sufficient account of the societal aspect of living. It is all very well to be living in Utopia and saying that normalization is the thing we should aim for, that we should have, and that it is just around the corner. The fact is that it does not exist as yet.

My own experience of 20 years at a medical drop-in, dealing with a lot of schizophrenics living in single, supported, independent living, is that none of you likely have any concept of the tremendous loneliness that most of these people suffer. Because of this loneliness, they sell their birthright. They have all sorts of friends for the first week and none for the second. I will not go into all the other horrors that occur through trying to buy or obtain friendship. It is something that those of us who are fortunate here cannot begin to imagine, what these people who are lonely will do to try to get a friend who will bunk in with them, who will then scrounge from them, raid their larder and everything else.

I think we very much need to think of a societal model. At present, unless we are able to change society so that we have a great many more volunteers, in many instances people are going to be imprisoned in their group homes unless they have somebody to take them out, because unless everybody goes out at the same time nobody is going to go out, unless you have an extra person to deal with that trip or transportation.

I believe some thought has to be given to this aspect, and I do think that some of you may not realize that there are parents who believe, quite honestly, that their children are better off at present in a congregate model, cottages on an estate, on one of the schedule 1 facilities where they have a great deal of freedom. They get into towns and they have trips and various other things and we know that they are safe. Many of these people cannot be trained. They do not have the reflexes to react quickly enough to traffic problems, or other problems, for that matter.

I think there is something to be said for this sort of setup, which should be included. It is not excluding anything else. Everybody is individual. Give them a chance. If it does not work, though, do not push it, but take them back and try something else.

The trouble with Challenges and Opportunities is that it is a one-way street; you can only go one way. You are expected to be ever better and to go from one stage of productivity or creativity to another. We all know that most of our clients are going to age more quickly, they are going to lose their skills, and unless they are stimulated maximally, which they are, by and large, in an institution, they are going to lose a great many of their skills. You see it all the time.

The Vice-Chair: I have two more questioners, Mrs McLeod and Mr Jackson, with approximately seven minutes left.

Mrs McLeod: I appreciate what you are saying and I think I understand it, but I am struggling with it. I guess the reason I am struggling is that I have been peripherally

aware of the field for some 20 years, and when the first trainable mentally retarded classes were being mainstreamed into the regular school setting, I suppose at that time I wondered how it could work and went on to see how well in fact that worked. But I continued to remain sceptical that the more severely developmentally delayed could ever be mainstreamed into a regular school setting to any degree at all, and discovered some years later that in fact some quite marvellous things had been achieved in that direction.

So the reason I struggle, and I am sure I have not anguished with it to nearly the same extent and with the same constancy you people have, is that issue: How do we define the limits of what is possible? Particularly, how does government set those kinds of limits, and are we in danger, if we try to define what is possible in terms of community living, of limiting the support we provide? I think the point you make is that it requires tremendous support for community living to be successful. If we do not have some conviction that it can work without setting limits around it, we will set limits on that support.

To make it a question, do you not feel that if we were to maintain an institutional setting as a choice, by the very fact of doing that and by the realities of doing that—as you indicated, we have to be realistic—that would limit the choices for community living that we could provide?

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Mrs Paproski: I think, if you look at the cost figures of the operation of an institution versus the costs of operating group homes, you will find that it is infinitely cheaper to have people in congregate care. That is taking the person out of it and saying that we are just looking at the dollar figures. But we have to look at dollar figures. How can you maximize the use of your dollar figures to provide the most opportunities for the most number of people? We have had to face that as parents.

You talk about mainstreaming in the schools and yes there have been tremendous successes. Unfortunately, we do not hear about the failures. My daughter was a failure in a trainable mentally retarded school. We had her in England for two years where she was in a special school where she received one to one. When we came back, she could not cope with the stimulus of the TMR school and because she had very extreme epilepsy they could not cope with her epilepsy. We do not hear about all the failures.

What we are asking for is a recognition of the very special needs of probably a very small portion of the population. But just as we recognize the needs of senior citizens as they become more disabled and try to provide support for them, whether it be in the home or eventually in an institution when the home can no longer support them, I think developmentally handicapped people should also have that type of option. I would have to say that people who live in institutions and have experienced life in the community often want to go back to the institution; it is their friends.

Mrs McLeod: I am appreciative of the very high degrees of support that are needed by the severely developmentally delayed, but for an institution to exist as we know

t, it requires a fairly large population. As I hear you describing this small and fairly select group of people who need what you are describing as institutional care, it sounds to me as though you are talking about something very different from the institutions as we know them, almost to the point of a somewhat larger group home model.

Mrs Paproski: It is quite possible. We figure this is the government's job, to determine what the figures should be for the population and what is cost-effective. That is why we have been asking the question for the past six years. We have said that we were never opposed to the closure of institutions if the move from the institution could be proved to be better and could be done, but we must always take into consideration the social needs of people. It is not sufficient to move somebody into a group home where they sit and look at the other four or five people all day. That is not putting them into a community. The institution is a greater community where they can move about freely. They can choose their friends not just from the people with whom they live or with whom they work. This is a question that I think this government has to address.

Mr Jackson: I did not appreciate the brief as much. I have read the material that has come from your association; you have been kind enough to send it to me. I do not necessarily share your view and I think it is fair that I share that with you. I think we all can be imprisoned by our own opinions. The doctor referred to being imprisoned in community living settings and we have had ample evidence of that being described about life in institutions. In spite of that difference we share fundamentally, I would like to ask you if you are concerned with some of the information about the use of restraints, the use of locking—this is the only non-criminal element in society, that we lock up in an institutional setting or any setting for that matter—and further, if you acknowledge, for example, the incident at Brantwood, that it should be subjected to a provincial inquiry. I am just trying to get a clearer sense of your thrust. By focusing on the multi-year plan so much perhaps you are not focusing on the very things that you agree with community living in terms of life in institutions that need serious reforms and perhaps the public has been denied the real truth about institutional living.

Dr Bruce-Robertson: I think, as always, it is a tremendous dilemma as to how much you should allow a person to self-destruct. We have the same problem in simple life. How far are you going to go to prevent a person from committing suicide?

Mr Jackson: No, I am sorry. I know you are a coalition of eight various groups. I understand the concerns within the Friends of Schizophrenics organization and I know its position vis-à-vis your position and it is different. We do not wish to get convoluted with persons with mental illnesses. We would hope that as a practising physician in this province you have not made the distinction. We would like you to speak purely to developmental disabilities as we understand them and not the schizophrenic. That is your second reference to that and I would like that to be clear.

Mrs Paproski: Excuse me, I think we have done this. I have just a short word before you answer. You must recognize that a good number of the people in institutions are dual-diagnosed. They do have psychiatric disorders. They are not simply developmentally delayed.

Mr Jackson: I understand that, but it would have been helpful to make that distinction. I would hope we would not be talking about that group at this time.

Dr Bruce-Robertson: I was just saying, though, that to me there is a great parallel and that many developmentally disabled can make a decision that any one of us would think is contrary to their best interests. How far you go to prevent that, whether it is by constraints or sedation and so forth, I think is a very difficult question.

Mr Jackson: Even shock therapy. Sorry, that is scary.

The Vice-Chair: I am sorry. We have run out of time. I apologize, but we do have to move on. Thank you for your presentation.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Vice-Chair: Our final presentation is from the Ontario Public Service Employees Union. Please come forward. Welcome to the committee. I would ask that you identify yourselves and I would remind you that you have half an hour and you can divide that half hour as you deem fit. You may allow for questions at the end of your presentation. Please proceed.

Ms Whitehead: I am Carol Whitehead and this is Nick Di Salle. We are both research education officers at OPSEU.

We welcome this opportunity to express some of our concerns about the multi-year plan. It is not our position to do a comprehensive analysis of the plan. What we will do is offer you some of the concerns we hear from our membership as well as ideas that we believe would help in our mutual concern to address the needs of the developmentally disabled. We express these concerns in general terms because we feel it is more appropriate to discuss the substance in a forum that includes other constituents.

We know that you are truly committed to addressing the needs of the developmentally disabled in Ontario. We hope that you will take seriously our concerns around the MYP. We know that you also want to be truly responsive to and representative of the various communities and interests that you serve. In order to do this in a meaningful way and address the needs of the developmentally disabled in this province, we make one recommendation very strongly: Establish a task force to do a comprehensive analysis of the current system of care for the developmentally disabled in Ontario. This task force should include consumers and their families where possible, parent groups, community advocates and front-line bargaining unit staff. OPSEU would be pleased to serve on such a committee and we are sure that others concerned about this issue would be willing also.

This committee will enable all of us concerned about the issue to look at what parts of the MYP have been working well and what have not and together develop

strategies to put services to the developmentally disabled on the right track.

The debate about how to best deliver services to the developmentally disabled is a long-standing one. Over the past decade, Ontario's provincial governments have chosen to divest these services under the guise of communityization following the pattern established with the deinstitutionalization of psychiatric patients.

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Divestment of developmentally disabled facilities began under the former Conservative Comsoc minister Frank Drea, who was a strong proponent of low-cost options for the disabled at any cost to the disabled themselves. This divestment was motivated by a desire to distance government from the administration and delivery of services in order to gradually withdraw its level of funding without being held accountable for the outcome; in short, to nickel-and-dime services to the developmentally disabled and the community agencies that serve them.

We should collectively and co-operatively reassess both the types of services and funding structures to services for this community. It is our view that if the new government is committed to responsible care for the disabled, with community control and community-based services, a comprehensive review of the current system must be done before the current plan is fully implemented, not after. Otherwise, we will be confronted with more Cedar Glens, and we fear that care for the developmentally disabled around the province will be worse instead of better. OPSEU is committed to working with the community and government to jointly develop a high-quality, consistent system of care for the developmentally disabled.

It is our belief that an effective system of care should at least include the following principles:

1. That the community of the developmentally disabled is as varied as the population as a whole. Therefore, a truly effective system of services will contain a continuum of living models; for instance, village within a village, groups homes, family support programs, etc. The government should explore these options fully, many of which are successfully used around Ontario and in other parts of the world, before it places people into situations which are often worse than those in which they now live.

2. This system must be open-ended, enabling people to flow through the system as they need, not as bureaucratic plans dictate.

3. Clients, and their families where appropriate, should have the choice as to where and how they wish to live and when and if they want to move. Again, this choice should not be predetermined by any bureaucratic plan, but according to the clients' needs.

4. The system must provide a quality of working life that will permit direct care staff to effectively and efficiently deliver the needed services. Currently, many facilities are underfunded, understaffed and undertrained—as I am sure you have been hearing—a situation that serves no one well. The quality of work life of front-line staff is crucial to the success of community integration. As anyone working in the human services can attest to, if staff are

undervalued and working conditions are bad, service to clients will suffer.

5. The communityization movement to this point has not fully met the objectives of its promoters—normalization—mainly because of a lack of adequate funding to meet the true needs of community-based service delivery. Funding arrangements that reflect the actual financial needs of community services must be developed again before more developmentally disabled people are dumped into underfunded community agencies.

6. The multitude of different employers in the developmentally disabled field has led to the current situation of erratic, inconsistent staff training and wages around the province. There is a need for provincial standards for staff training and qualifications in order to ensure consistent and high-quality delivery of service. Also, sectoral bargaining for workers doing the same work in the same field should be considered.

7. The placement process for clients in any facility must be an open and responsible one involving residents and their families where appropriate, front-line staff, community agencies, etc. The goal of placement must be to provide residents with the broadest possible perspective of available living alternatives, rather than forced movement due to bureaucratic rationales.

8. The system must be completely and adequately funded by the provincial government. Funding for service to the developmentally disabled should not and must not be dependent on charities or successful fund-raising.

OPSEU is not opposed to deinstitutionalization. Our concerns with the multi-year plan stem from the fact that this plan was formulated by governments whose motivations were political and fiscal and had little to do with ensuring the development of high-quality, consistent, adequately funded alternative living models.

The prime motivation initially of the MYP was simply to eliminate one option of care for the disabled, large residential facilities, with little concern for the clients or staff. It failed to provide the full range of services or living alternatives we believe the developmentally disabled, their families, front-line workers and the community deserve, and also failed to ensure the safety of the developmentally disabled in society.

The following are some of our concerns about the effects of the current MYP on society, as well as some of our concerns about the placement process and provision of services in the community. Again, however, we must underline that this list is not conclusive and we strongly believe that if the new government is committed to ensuring safe, quality care, a comprehensive investigation must be done with community and staff input.

Our summary of concerns about placement and process:

1. Placements currently are driven by numbers to be placed, determined by bureaucrats rather than by client needs and readiness. As the MYP is currently structured, each region determines how many clients must be moved in a given time frame in order to fulfil the bureaucratic aims of the plan; ie, to close large facilities. If I could just interject, I believe that has been modified somewhat

different bureaucrats determine the numbers of clients. However, our point remains that placements are determined by bureaucratic rationale. Client need and readiness for placement is secondary to the bureaucratic decisions to close institutions and move specified numbers of clients within certain time frames.

2. The numbers of clients to be moved are determined by regional managers, with no input from clients, their families or advocates, or front-line staff who know the clients.

3. We also have grave concerns about some of the facilities used and appropriateness of some placements. Recently our members have reported situations where clients have been readmitted to large institutions because their group home placements and staff are ill equipped to deal with them. This situation must be fully investigated before more people are placed in facilities which may very well be worse than their current one, if not downright dangerous.

4. The current lack of provincial standards for staff training and staffing levels is of grave concern to us.

5. Insufficient or non-existent monitoring of conditions in facilities, as evidenced by the recent inquest at Cedar Glen Boarding Home and the auditor's report, must be addressed. It is irresponsible to place clients into facilities that are not inspected and monitored sufficiently.

6. Clients who have returned to facilities requesting readmission have been turned away because of the current focus on closing institutions regardless of client need.

7. Tracking of clients to assess and ensure their coping in the community is inconsistent, sporadic and sometimes totally non-existent. As a general rule, it is for a very limited time period; for someone who might need support services for the rest of their life, this does not seem sufficient.

8. Our members in corrections and psychiatric facilities express concern at a seeming increase in the numbers of developmentally disabled in their institutions in the last few years. We suspect a correlation between this and the multi-year plan in its current form.

9. The current system is not open-ended, with a variety of types of facilities and services available, and clients are not able to move throughout the system as they need.

10. Clients and their families have little choice in type of placement models available. Some of the few facilities that offer a variety of residential styles are being divested.

11. Services are not readily available in all communities.

12. Health services in the community are often unable to deal with the client; even the Canadian Medical Association has expressed this concern.

13. Current schedule 1 facility staff are provided few acceptable opportunities to remain in the field of service delivery, despite having devoted their lives to this field.

Effects on the community: As the multi-year plan is currently formulated, those who suffer most from its problems are the residents and those who take care of them, whether they are workers in the facilities, workers or volunteers in related organizations, home care workers or family. These helpers are predominantly women.

The MYP has operated as a policy benefiting government whose priorities are not people, at the expense of some of the most marginalized and exploited people in our society and women. It is, in its current formulation, a discriminatory policy because women bear the brunt of care if they want to look after their own families or members of their own communities. Governments have used this policy to reduce their deficits and provide cut-rate or free services by often using women as employees to do the same work for less money in community agencies.

Above are a few of our general, and in many cases fundamental, concerns about MYP as it currently stands. As we stated earlier, we believe very strongly that to act responsibly, the new government must initiate a review and assessment of the current MYP. This must be done before the plan is fully implemented, or more Cedar Glens will occur.

OPSEU's commitment to social unionism is a matter of record and we will continue to strive towards a more socially just and responsible society. We look forward to working with government and all others concerned about this issue to develop and enhance social services and programs available to the developmentally disabled.

Mr Owens: I would like to thank you folks for your presentation and the rapidity with which it was put together for your presentation today. I would like to address my questions to sections 3, 4 and 5 in your summary of concerns of that placement process.

My first question is about the revolving-door syndrome that you address, with clients rotating back to institutions from group homes due to poor staffing or because their staff is ill equipped to deal with them. Do you have any sense of numbers as to how many people have been rotated back and forth? Does it occur with some regularity? To your knowledge, is the ministry tracking this type of problem with a view to perhaps resolving this kind of an issue? I do not think you need to be a rocket scientist to figure out the impact that this type of revolving door has on both the client and the staff, as well as the family involved.

1700

I guess sections 4 and 5 essentially could be melded into one. The CUPE local that represents the folks that work in the group homes essentially expressed the same type of concerns about standards and training as well as inspections within their own group homes.

Could you just elaborate a little bit more on whether inspections do take place, how often they do take place, and are institutions forewarned of an impending inspection so as to allow time for any kind of preparation or cleanup or painting of the walls or whatever folks do with these inspections?

Mr Di Salle: I think it is a difficult question to answer, specifically because there is a lack of tracking, there is a lack of monitoring. Most of our members who work in this field report to us on an ad hoc basis when this happens. We have tried over the last year to start monitoring it ourselves. We feel that it is not our job to monitor breakdowns in placements. We

have continuously approached the government, on several occasions, to work with us in monitoring the success or failure rates of people moving into group homes.

I was up in Huronia last summer and I spoke to several members. I cannot give you specific names and dates because it is confidential. But several people who were placed from that facility—one in particular apparently was quite destructive and in one of the group homes the furniture after a few weeks was destroyed and this client was returned to the institution. They said, "We can't handle him."

Stories like that keep coming to us. It is difficult for me to give you numbers because we have a variety of different members, both in institutions and in the community. But that is one thing I think is essential, and we have asked for it in our brief, that a proper monitoring and tracking system be established.

We had similar problems with the ex-psychiatric patients that would be institutionalized. We discovered a secret report by government that over 900 of these people were in fact in correctional facilities. That has nothing to do with developmentally handicapped, but I am saying it is the same problem. There is no system to follow them, to find out how they are doing. It is very haphazard; in some cases a three-month follow-up, in other cases a six-month follow-up, but there is no standard. That is one of the major problems.

Mrs McLeod: I am quite prepared to accept the fact that the concerns that OPSEU brings to this are concerns for the clients and the people involved. I would have hoped you would have understood that the concerns the government had in instituting the multi-year plan were equally motivated by concern for the client.

I was a little distressed, obviously, to note the references to fiscal and political gains. I was part of one of those governments and I can assure you that there was no political gain expected, sought or realized in any way, and certainly there was no expectation that there would be a financial saving through moving people into the community, that if the supports are to be provided that are needed for community living to be successful, it could be equally or more costly than the program of maintaining people in an institutional setting.

There is no denying that there are problems, and one of the reasons why this committee is wanting to have the hearings is to be able to focus on how successfully the plan is being carried and, where there are problems, to encourage government to deal with those problems in a very real way so that common goals are being achieved.

I worry a bit when the references are made to the psychiatric deinstitutionalization because I think, as we look back on that, it is one we need to learn from, that the community supports were not in place and there were problems at follow-through. But I would hope we would not put the two into the same discussion because there was a real effort made to deal with this in a very different way than the psychiatric deinstitutionalization that was carried out.

To make a very brief question, if the problems can be addressed, if the supports can be provided, do you feel

OPSEU would in fact be supportive of deinstitutionalization?

Mr Di Salle: I think we stated that fairly clearly and categorically. We are in favour of deinstitutionalization. The problem is in the way it is implemented. That is what is bothering us. To clarify the political reference, there is no doubt in our minds that in the late 1970s there was a growing political desire to distance the government, whether federal or provincial, from the direct delivery of services. Coincidentally, the community started to require more and more empowerment and these two desires seemed to fit very neatly together. We understand why the communitization, but we would like to clarify some of the motivations behind government.

You may disagree, but it is our opinion that it is in fact a Reagan-Thatcher type of neo-conservative thinking that says government must be out of this service. It happened to fit neatly with the desire of communities to say we want more empowerment. But the government's intention was, I think, to dump the complete responsibility for these people on to the community without the proper funding.

We believe in communitization and we believe in deinstitutionalization. But we also believe strongly that these individuals and their families should not be pushed around by bureaucratic plans. We believe they should have the choice, and one of those choices might be a medium institution, a large institution. I was listening to your question earlier on about what size an institution should be. That is something that should evolve with time. It should not be dictated by bureaucracy or by political desires.

Mrs McLeod: This will not be a question, but just follow-up comment. It is not a coincidence if government direction happens to fit neatly with community desire. I think it is a responsibility of government to respond to the interests of the community. I do not have a need to attribute different motivations for that.

Mr Di Salle: We see different motivations.

Mr Jackson: I have a whole series of questions and know time is limited, so let me just ask you, what the hell are you talking about with discovering a secret government report as it relates to 900 residents? What are you talking about here?

Mr Di Salle: As I said, it did not relate to this issue.

Mr Jackson: Then why did you bring it up?

Mr Di Salle: To explain the problem of trying to trap people and to find out how they are doing in the community. When they put in the deinstitutionalization of psychiatric patients, they did not follow up, and consequently people ended up in the wrong place.

Mr Jackson: What did you do with this report when you got a copy of it? Did you make it available to anybody?

Mr Di Salle: I do not think that is the issue here.

Mr Jackson: You say you have the interests of the residents at heart. Do you not think that giving this kind of report daylight, exposing it, would help the residents? Why would you allow it to remain secret and use it in what I consider a rather offensive way before this committee?

Mr Di Salle: It is no longer a secret, Mr Jackson. It was in fact released, but it was for a long time held away from the public.

Mr Jackson: By both you and the government apparently.

Ms Whitehead: As soon as we got it, it was released in a press release that OPSEU put out as soon as we heard about it.

Mr Jackson: Okay. I have read the OPSEU memo that was sent out where you referred to you have stopped everybody, only those with their bags packed, that you have won your fight at the local level. Does that sound very much as if you yourselves are not embroiled in a political and fiscal battle?

Mr Di Salle: No, not at all.

Mr Jackson: Are you not meeting your own perceptions of government with similar action?

Mr Di Salle: No, not at all.

Mr Jackson: There was an information picket in Oakville at the Oaklands Regional Centre. It is controversial at the moment, no question about it. But there was not an effort to help take the issues of the residents' concerns and relating to them the issues of the multi-year plan. That is why I have circulated this to the members of the committee, "Oaklands Workers Call For Change."

We are getting some interesting things from your union. For example, during the information picket they were handing out pamphlets warning that local businesses have been ransacked and that you are somehow unsafe putting these people out into the community. It goes on to our local representative in discussions with the media saying that parents really do not want their children taken out of institutions. Is that the kind of conduct you are endorsing in terms of information about the sensitive issues involving deinstitutionalization and the legitimate right of those individuals who would like to leave institutions?

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Mr Di Salle: I think the union is on record, and we have repeated it today, that we believe that people who are in institutions have a perfect right to leave and have a perfect right to choose where they would like to live. Our members are probably raising some of the concerns that they have observed in the community, but our members are not against people leaving.

Mr Jackson: So you do not agree with the statement that most parents do not want their children leaving facilities. You do not agree with that statement.

Mr Di Salle: I did not say I did not agree with that statement.

Mr Jackson: I asked if you did.

Mr Di Salle: There are parents who do not want their children to leave the institution because they feel there is better care in the institution than they would get in the community. Of course, I do not know what every parent thinks. It is pretty difficult to find out.

Mr Jackson: The final question has to do with the issue of Brantwood, and you were careful to only reference Cedar Glen and not Brantwood. Do you believe there should be a full public inquiry into the Brantwood situation? Do you support that?

Mr Di Salle: I think that standards and inspections need to be more structured, of course, to prevent that type of thing from happening.

Mr Jackson: Carol is nodding her head. I just asked a simple question: Do you support a full public inquiry?

Mr Di Salle: That is up to the government. We would probably like to get involved in finding out what is going on in some of these places, but certainly we would support looking into that.

Mr Malkowski: Your information has been helpful. From the other presentations that we have heard this afternoon, the People First group, as well as the parents who support community living, they feel the institutions should be closed and all residents should move to community living. Do you feel that the institutions should be closed but perhaps become resource centres to provide services to the community? How do you feel about that?

Mr Di Salle: I travelled to all the institutions over the last year and a half and there is a tremendous variety of people living in institutions. Do not forget, OPSEU has almost 2,000 people organized who deliver community-based services, and I say the majority of them are in agreement in saying that in some instances some types of clients do in fact need the services available through an institution or through a large residential facility. How many of them there should be and how large they should be is something that I think we will clarify with time, but I do not believe that personally, from what I have seen, there will come a time when there will be no need whatsoever for a large residential facility. I find that hard to believe.

Mr Malkowski: I would also just like to make a point around the use of the term "institution." When I hear the term, I certainly shudder and I think back to 18th century horror stories. It feels jail-like. I do not know how many of you on the committee have yet had a chance to tour around some of the facilities. Recently I visited Darcy Place—and I presume by "institution" that you are referring to the schedule 1 government facilities. I do not know how many of you had a chance in particular to visit Darcy Place and Edgar, both of which are referred to as institutions. They are just lumped in, but as far as I am concerned I was quite pleasantly surprised that they had nothing to do with what I thought institutions would be. They really are communities. So I think it would be useful for members on the committee, if you are going to be investigating this issue further, to visit them and get a sense of what the options currently are. I have found that incredibly useful myself and I think that the use of the word "institution" really clouds the issue.

Mr Di Salle: I would like to add something to that, and I think it refers back to what Mrs McLeod was talking about earlier, that the government not only thinks institutions are large residential facilities, it has an opportunity to diversify them into group homes and

run them, where the standards are kept up, where the staff is well paid, where the staff has opportunities. But what the government then does, it goes a step further and divests that. It says, "We don't want to run it at all any more." It is not a question of their simply providing a community service. The government can provide community-based services. It is when they start divesting them to non-profit boards that we see their real motivation.

I had a letter that was written by the previous minister, Mr Sweeney, and it shows a breakdown of transfer payments to divested institutions, divested services and government-run facilities. Over a seven- or eight-year period, you saw an 11% or 12% difference. It is the nickel-and-diming opportunity that they have once they have divested this. They divest it and then they fool around with the funding and 10 years later you find out you are running to the local United Way or to a charity or you are doing fund-raising to meet your budget. That, I think, is the hidden agenda that we have to be careful of.

Mr White: On a point of information: I think Mr Beer was the previous minister.

Mr Di Salle: Before Mr Beer, sorry.

Mr Malkowski: Does your union provide information to parents or consumers about their rights and the choices that are available to them to live in the community?

Mr Di Salle: We have been asking repeatedly that our members be involved in the consulting phase with parents in the initial meetings about placements. We would hope that this would become a regular process, that our people can be involved.

The Vice-Chair: Okay. We have come to the end of the time. Thank you for your presentation. We should stop our clock at this point. But before members of the committee leave, we have a couple of items to attend to. First of all, let me thank all of the committee members for their co-operation in getting through this marathon session today. I appreciate your co-operation.

The first item to deal with is instructions to our research officer, Alison, for tomorrow, the subcommittee meeting at 1 pm in room 1545 in the Whitney Block. Can we turn to Charles Beer for that?

Mr Beer: Subject to what others think, it might be most helpful if Alison could do a summary of the recommendations that were contained in the reports, as she did before. It may well be that she wants to do some of the introductory work just to make use of time, but I would think probably what we would want to focus on would be our recommendations.

I think we are going to try before that meeting to have some sense of some of the things that we would like to do,

and I assume others would do the same. If Alison was able to do that, I think that would be particularly helpful.

Ms Drummond: Okay, what I thought I would do is try to distribute a quick summary of the recommendations, only the ones that have been made by witnesses, and try to get that to the subcommittee tomorrow morning. Does that seem reasonable? Then you could decide and you could distribute it.

The Vice-Chair: We could get it to their offices before the meeting.

Ms Drummond: At some point late in the morning so that you can look at it before the meeting, so that is a piece of paper that we are all working from. Does that seem reasonable?

The Vice-Chair: Is that agreeable?

Mr Jackson: Can we get the recommendations categorized? It would be a help.

The Vice-Chair: It would be similar to what you presented in the last segment.

Ms Drummond: Certainly they will all be identified by who made them. I can organize them into topics a well, if that is helpful.

Mr Jackson: Yes, it is helpful. I will respect your natural groupings. I just find that in that form it is far easier to read and develop a consensus.

The Vice-Chair: Is that agreeable to everyone? All right.

The second item is that we will have the full committee meeting on Thursday at 2 pm to finalize the report. We have approximately three hours left, give or take. The clerk reminds me we have two hours and 58 minutes exactly. There you have it. Is that acceptable to everyone? Whether it is or is not, we have already scheduled Thursday's meeting, so we cannot change it.

Mr Jackson: I have one issue I wish to raise and will just flag the committee on it now. It may have escaped our first week's activity. That is with respect to the issue of publishing a report, the number of copies and the languages used. I will raise it tomorrow in subcommittee. There are two subcommittees now operating simultaneously.

Clerk of the Committee: The subcommittee report that was deemed to be adopted covered the languages for the report, which were both official languages. It also covered the tabling of the report if the report was not available in both languages when the House came back. The report were being tabled then and it would be in one language—

Mr Jackson: We can discuss this tomorrow, because we are going to have some blockages here, no doubt.

The committee adjourned at 1721.

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**Official Report
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Thursday 24 January 1991

**Standing committee on
social development**

Service mandate for
developmentally handicapped



**Assemblée législative
de l'Ontario**

Première session, 35^e législature

**Journal
des débats
(Hansard)**

Le jeudi 24 janvier 1991

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affaires sociales**

Mandat de services relatifs aux
déficiences mentales

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 24 January 1991

The committee met at 1402 in committee room 2.

SERVICE MANDATE FOR DEVELOPMENTALLY HANDICAPPED

Resuming consideration of the designated matter of valuation of service mandate for individuals with developmental handicaps, multi-year plan, pursuant to standing order 123.

The Vice-Chair: I will call the committee to order. We will recess for 20 minutes so that members can read the draft report prepared by Alison Drummond.

The committee recessed at 1403.

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DRAFT REPORT

The Vice-Chair: Members, can we get going on this? I would like to start off with the section on recommendations and we can go through that.

Mr Owens: Could I just make a quick recommendation that we do as we did with the children's mental health report: we just flag contentious issues and leave those until the end for any further discussion?

The Vice-Chair: Sure. We will go through it step by step and those contentious issues, as they come up, we will leave to the end.

We will turn to Alison to take us through the sections.

Ms Drummond: If you will turn to page 10 of the document that Lynn had waiting for you at 2 o'clock, there is a brief preamble, as there was with the recommendations under children's mental health services. Then the recommendations have been organized in a very similar manner, with a brief preamble where it seemed relevant. The first section addresses the policies and programs under the multi-year plan. The second section addresses funding issues. The third section addresses advocacy and protection, which were issues which were raised a good deal in committee. After that, there is a section on training and human resources co-ordination, legislation and special needs groups. I hope it is self-explanatory.

The Vice-Chair: Perhaps we could start with the preamble and we can go through each section. Any comments in the preamble? Any discussion? Okay, all those agreeing with the preamble. Carried.

Section 2, multi-year plan: policies and programs.

Mr Jackson: Mr Chair, in the second bullet, is it possible to further clarify the point I was hoping to achieve here: that services in the community be established to address the needs of developmentally handicapped people, whose aging parents have previously cared for them at home, on the waiting list for community services as well as people who are leaving institutions?

I just wanted to make it abundantly clear that these people are on waiting lists for support of some form and

that they are being cared for at home. We tend to get confused with this concept that they are in the community, but they are in the community at home, not in the community at a halfway house.

The Vice-Chair: Do you want to repeat that?

Mr Jackson: I will pick it up in the second bullet, "whose aging parents have previously cared for them at home and are on the waiting list for community services." That was the nature of their concern that was expressed to us. It almost implies that these aging parents could be a mile away or in a neighbouring community. It does not imply clearly that we are talking about families who are maintaining care in their home with the family member and they are worried that they have to go to a nursing home and have no place for their son or daughter who is living in the home with them and they are on current waiting lists for a location and service.

Mrs McLeod: If we are being that specific with this particular point, and I appreciate the fact that it is geared to those who can no longer stay at home and therefore need a placement as opposed to job support, etc, it should probably read clearly "residential services." We are not talking about the broad scope of services at this point.

The Vice-Chair: You are making a distinction there.

Mr Jackson: I consider both. These are not a high priority for community-based relief programs and they are not at all on a priority listing for community residential. We are simply saying this is a bundle of community services which are residential and relief home care. The operative part here is that we were impressed by how important that need is without getting into which was the greater need, finding another home for them or finding parent relief.

Mr Owens: Could we address your concern by using the word "support services" in place of "community services" as a catch-all?

Mr Jackson: No. People First would object because the support service would be to institutionalize them, so they would not accept the loose interpretation of that. Community services are community services; they are not institutional services.

Mr Owens: How about "support services"?

Mr Jackson: We are saying the same thing then, are we not?

The Vice-Chair: "Community support services."

Mr Jackson: What is wrong with "community services"?

The Vice-Chair: I am trying.

Mr Jackson: I know. I think there is agreement on that.

Mrs McLeod: My only concern is that as we describe a broad range of services in the community, we do not

want to appear in any way to be limiting those to people who are moving out of a home setting and into a community residence setting. We want to be able to ensure that the broader-base services continue to be equally available to those who are still living with the family. I was just concerned that we are beginning to be so focused on those who are moving out of the home into a community residence that we may be losing our focus on the broader-base community service to the others as well.

The Vice-Chair: Specifically, your concern would be towards the whole motion of residential services? I am just trying to get it clear so that we all understand the differences.

Mrs McLeod: It might be possible to deal with it on page 11, when we get to that one, on the second bullet point just to ensure that that broad-based support is available to all of the people who are in need of those services.

1430

Mr Jackson: Mrs McLeod's thoughts are helpful, but they are not moving in the direction I want this to go in. If we ask the community that we spoke to for the last three days what it considers its number one problem, it is generally coming to the conclusion that we really do not have programs in place for the person at home who is being taken care of by an aging parent. I get that from Brian Low, whether it is the ministry—I get it from the association.

The Vice-Chair: I think we have agreement.

Mrs McLeod: We are agreeing on that.

Mr Jackson: All right.

The Vice-Chair: It is a question of finding the appropriate wording.

Mrs McLeod: I think we would be comfortable with Mr Jackson's wording on that one, as long as we can have another point in the document where we ensure that the broader-based community services are equally accessible.

Mr Jackson: Then might I suggest that we proceed with my wording, and that gives Lyn and Charles 5 or 10 minutes to develop the spot at which they would like their expanded wording to appear and then we can proceed.

The Vice-Chair: I think it was suggested that their points should be made on page 11, under the multi-year plan funding section.

Mr Jackson: Then let them do that and when we get to that point they can speak to it. At this point they have agreed that my wording was fine and we could proceed. That is what I heard.

The Vice-Chair: Is that acceptable to you, Mrs McLeod?

Mrs McLeod: Conditionally.

The Vice-Chair: Okay, conditionally. Mr Owens, is that acceptable to you?

Mr Owens: Could we see the final wording on that?

The Vice-Chair: Perhaps Alison has it.

Ms Drummond: Could I read it as I have it, and then we can see if that is what everybody wanted?

The second bullet point to read: "Services in the community be established to address the needs of developmentally handicapped people whose aging parents have previously cared for them at home and are on the waiting list for community services, as well as people who are leaving institutions."

The Vice-Chair: Is that acceptable? Okay, we have agreement on that. Any other matters pertaining to this section?

Mr Beer: In the fourth bullet in the group that we are dealing with on page 10, it seems to me there are two groups that also need to be included in the discussion: where people are being transferred. If I could suggest this "Developmentally handicapped individuals and their families, as well as front-line workers in facilities and service providers at the community level, be informed of and involved in..."

What I am just trying to catch there is that I think we do want to make sure that those who are working in the institutions and in the group homes are aware of and are involved in the planning. I think those points came forward in a number of briefs, not just from the union representatives but others, and indeed we would want to ensure that that kind of consultation took place.

I will read that again if it is helpful: "Developmentally handicapped individuals and their families, as well as front-line workers in facilities and service providers at the community level, be informed of and involved in planning moves from institutions and other transfers between settings."

It just seemed to me that would then capture all of those with the likelihood to be involved and make it clear that there should be that consultation, because all of those folks would be affected or could be affected.

The Vice-Chair: Is everyone agreeable? Okay. I will make that amendment. Now we will go on to the second part of that section.

Mr Jackson: Starting "parent relief programs"?

The Vice-Chair: Right.

Mr Jackson: I have a further addition to that if you are accepting it.

The Vice-Chair: Yes; now is the time to do it.

Mr Jackson: I would like to add a refinement of the first bullet. I will read it: "Flexible funding for expanded parent relief that recognizes significant specialized staffing costs; for example, nurses for children with complex medical needs." We heard that. We are saying that the parent relief is confined within a range but that the flexibility should also be in terms of whom we can access and would be more helpful at that time. It implies more than just flexibility of hours and flexibility of access but the flexibility of the kinds of support received. That is what I am trying to further refine with that recommendation.

Mr Owens: The issue of flexible funding is addressed later on in the recommendations. I think there is an agreement with all parties on this issue and I think that specific recommendation around parent relief programs should stand reasonably intact, because again, the issue is

flexibility and funding and programs being individualized or needs, as opposed to systemic needs, is addressed in the latter portion of the recommendations.

Mr Jackson: Where specifically?

Mr White: The first bullet speaks to flexibility and portability.

Mr Jackson: That is correct. I thought I had made that clear, that there are three elements of flexibility that we've heard. This, in my view, generally refers to more of it and more flexible rules for its access. What is not here is that the range of support is part of a flexibility context that we support and they do not get certain nursing interventions or support, because it is not part of the criteria.

People were saying, "You are sending me essentially a baby-sitter, but my child specifically needs, because of the choking and the potential for the problems, the one-hour feeding." I am trying to put in context how that was conveyed to us, that you need somebody with very specialized training, and parent relief does not address that under its current terms of reference. That is the flexibility they were asking for, "Please, be flexible enough," so that when you only need a baby-sitter, you have a baby-sitter, and when you need someone with medical-dietary skills, you negotiate and work on an ability to get that, otherwise the mother cannot leave the home during a feeding period. The mother cannot leave in a period when they are expecting a grand mal seizure and those kinds of things. That is why I tried to be very clear about what I felt we could have enhanced with what we heard. We do not have to support that but that is what I heard and therefore that is how I interpret flexibility.

Mr Owens: I do not think it is a matter of whether or not we support it. We do support the intent of what you are saying. I think if we can boil it down to less verbiage to address the intent, then we might be a little—

Mr Jackson: I am not worried about the economies of paper here. I am more concerned with the clarity of the report so that our constituencies out there understand that we've heard them. Therefore, if it needs another half an inch of space in this report, I would be willing to invest in that.

Mr Owens: We are not, again, discussing—

Mr Jackson: Then I am having trouble understanding your point.

The Vice-Chair: Just a minute. Mr Beer wants to get point in.

Mr Beer: We could say, "Flexible parent relief programs, including respite care and other specialized nursing services where needed, be enhanced to provide relief to already overburdened families." Irrespective of whether residential services are or are not being developed, we would want flexible parent relief programs. Instead of saying "such," say "including respite care and specialized nursing services where needed," so that those are by way of example and not totally defining what a relief program would be. Then, "be enhanced to provide relief to already overburdened families." Because whatever the situation, if they are overburdened, then we are putting the emphasis

on "flexible." We have two examples of the kinds of things that were drawn to our attention, but they are not limiting.

1440

Mr White: I think Mr Beer's point is excellent. The other aspect to that is there is an implication with the last phrase that is presently there that those services will only be offered to children or developmentally challenged adults who are in fact on a waiting list for residential services. In fact, family respite services as we presently have them in my area are primarily for children who are at home. I think that is an excellent augmentation.

Mr Jackson: I did not feel those six words contributed to the recommendation anyway, so I support their deletion. In the interests of economy of words, we have left the impression that we support nursing support, and I was clear that I put an equal value on speech and other aspects of specialized support. I think Charles would agree that by tying it down the way he suggested, it meets the needs of nursing, but I am trying to hit down that there is a rigid definition of the types of services available, and flexibility to me means that in meeting a child's needs, we have to say that there are some times we will have specialized needs, and nursing is just one of them.

Mr Beer: Maybe if we just said, "and specialized services," either "including respite care and specialized services where needed" or "including respite care and other specialized services where needed," so that we are leaving open then the definition of what those services would be.

Mr Jackson: I thought the simplest way was to explain them.

The Vice-Chair: Do you accept Mr Beer's motion?

Mr Jackson: In the interests of time only.

The Vice-Chair: Okay, in the interests of time, it is accepted. I gather we have consensus on that. Shall we move on?

Mrs McLeod: Could I just make a proposal? It is not something that needs to be a big issue. I just want to ensure that we are continuing to be concerned about those individuals who live in a family setting. On the second bullet point on page 11, my suggestion would be, "Support to employment programs, job coaches and day programming be enhanced so as to be available to all developmentally handicapped individuals living in community settings."

The Vice-Chair: Acceptable? Agreed? Second bullet point on page 11.

Mrs McLeod: Shall I re-read it?

The Vice-Chair: Yes, please.

Mrs McLeod: "Support to employment programs, job coaches and day programming be enhanced so as to be available to all developmentally handicapped individuals living in community settings."

The Vice-Chair: Agreed? Okay. Any other items in this section for discussion?

Mr Jackson: Just a typo: "Grants received by colleges should be address any improvements needed." If we just recognize the typo, but other than that I am pleased

that it was tied down in accordance with our suggestion there.

The Vice-Chair: Okay, that is a typo.

Ms Drummond: Yes, just cross out "be." I have actually noticed another typo a little further down the page, so I will try to address that when we come to it.

Mr Jackson: I will not have to raise that one either, then.

The Vice-Chair: Okay. Multi-year plan policies and programs be included in the recommendations. Agreed? As amended? Shall it carry? Okay.

The multi-year plan funding section. Discussion?

Mr Owens: With respect to bullet point 2, I would like to set that aside temporarily for a later discussion as a contentious issue.

The Vice-Chair: All right.

Mr Beer: What was that again?

Mr Owens: Bullet point 2 under multi-year plan funding.

The Vice-Chair: Page 11.

Mr Jackson: I want a separate recorded vote here.

The Vice-Chair: Can you just read that out again?

Mr Owens: No, it is bullet point 2 on page 11.

The Vice-Chair: Any other matters in this section?

Ms Drummond: This section has the typo that I wanted to address. The third bullet, "A portable funding mechanism which ensures that funds follow the individual into the community," not "allow."

Mr Jackson: I would like to put in there that the Ministry of Community and Social Services recognizes one-time funding to community agencies to upgrade group home improvements as required by the retrofit regulations of the Ontario fire and building codes. I would like to add that in this area.

The Vice-Chair: Okay, a new bullet.

Mr Jackson: I have shared the wording with Alison. I will not speak to it at length.

The Vice-Chair: Perhaps, Mr Jackson, you could repeat that.

Mr Jackson: Okay. "The Ministry of Community and Social Services recognize one-time funding to community agencies to upgrade group home improvements as required by the retrofit regulations of the Ontario fire and building codes." This is a safety issue for any member in support of housing with the changes in fire and building codes and their being safer.

Mr Hope: Could I have Alison read that back, please?

Ms Drummond: Certainly. "The Ministry of Community and Social Services recognize one-time funding to community agencies to upgrade group home improvements as required by the retrofit regulations of the Ontario fire and building codes."

Mr White: I would say this is probably an excellent recommendation, but many of the developmentally challenged individuals in these group homes are multiply challenged. I am not sure what the ramifications of that would

be if we are talking of people who have cerebral palsy. There may be wheelchairs, a number of other issues, blindness, etc. I am not sure what the ramifications of that recommendation would be, given those extra factors, and I am not sure that we have time to study that costing at this particular moment on a Thursday afternoon.

The Vice-Chair: Mr Beer, Mrs McLeod, any comment? No? You are going to leave this one. Mr Jackson.

Mr Jackson: Just simply, there is not a single recommendation here that we have costed or studied from a costing position, so I just want to put that in perspective. Our only point from this was to identify the safety concerns, and we are not recommending the complete retrofit. We are asking this government to consider a one-time fund to address it. The concept comes up in several locations. We are not costing it because we expect the government to look at it and say that the will of this committee is that fire safety and compliance with the building code is a matter of concern. I do not want to be put in the position of it having been suggested to us and then not feeling it was important, and it was alluded to in one of the briefs. That is all.

I am not saying it has to occur in the next budget, which I know is a sensitive word for Mr Owens. I am not saying what year. I am simply saying this committee recognizes that the manner in which we have dealt with this in the past is to recommend one-time funding to assist those groups that have no funding base except from the government.

Mr White: One-time funding for each association and its capital expenses.

Mr Jackson: It is simply a recommendation to the government. It is not going to happen; it is just a recommendation.

Mr Owens: I hate to ruin—I cannot even remember his name now—Mr Jackson's day, but I would like to concur with his recommendation.

Mr Jackson: September 6 was the only day you ruined for me.

The Vice-Chair: Okay. We are agreed. Any other items for discussion in this section? We are on the funding section.

Mr Hope: On a point of order: We have a gentleman here and he has a list of things, and I think it is most appropriate that he be recognized by the Chair before discussion begins.

The Vice-Chair: I am sorry, I did not—

Mr Hope: What I am hearing is a lot of blurring out and no recognition from the Chair of who is to be identified as speaking.

1450

The Vice-Chair: Maybe I should have another cup of coffee.

Mr Jackson: I thought you had asked me when was I going to be ready to verbalize, and nobody said anything. He looked at me, and I said I had one more. I could not look at him and read my page at the same time, Randy. Maybe you can do that.

Mr White: You have hurt Mr Jackson's feelings, Mr Hope.

The Vice-Chair: I am sorry, I apologize if I overlooked someone, but I thought it was Mr Jackson who put up his hand and said he had another point of discussion on his section, so I turned to him.

Mr Jackson: And I was looking at my page to find it.

The Vice-Chair: If there is another member who wants the floor, I will recognize that other member.

Mr White: The concern I had, and perhaps the members opposite could assist in this issue, is something which has been addressed to the committee on a number of occasions: the problem of the local associations in really setting plans and in their infrastructure problems. The report here talks to a great degree about the co-operation among the government, the ministry and the local community services, but I believe the community services also have a need for support in service planning and with their infrastructure problems, such as was brought up during that long discussion. I am wondering if it might be possible to include some reference to that in this recommendation. I would welcome any response to that.

The Vice-Chair: Just for clarification, perhaps my clarification, we are still on the same point that was raised by Mr Jackson previously and you would like to amend that; is that right?

Mr White: I am sorry, I thought we had concluded Mr Jackson's concern.

The Vice-Chair: I thought we had too, but I am not sure at this point.

Mr Jackson: I found my last point.

Mr White: My apologies. I moved on to another issue.

The Vice-Chair: Okay, so this is another item. Accepted? Okay. We need some suggested wording so we can keep things moving right along. Do you have the phrasing for that recommendation?

Mr White: I had some. I hope it will be acceptable. I would welcome amendments to it. "Local associations be assisted in building up their infrastructures and in securing the consultative and planning services they need for matching with the multi-year plan."

The Vice-Chair: That is agreeable to everyone?

Mr White: I am sorry, "for matching the needs."

Mr Beer: Can you take it from the top?

The Vice-Chair: Repeat the whole thing.

Mrs McLeod: We are visual learners over here.

Mr White: I am sorry, I was going from the top of my head. "Local associations be funded to assist in the building up their infrastructures and in effectively planning to meet the needs of their clientele as suggested by the multi-year plan."

The Vice-Chair: That is good.

Mr White: My apologies; it was the off the top of my head.

Mr Jackson: Is there anyone here from the ministry who we can ask how we replace the word "infrastructure" for the word that was used in the multi-year plan? I do not wish to start reading to look for it, but I know "infrastructure" is not the word. Is there anybody in the room who can tell us the word to describe the network or whatever it is? "Infrastructure" is not the word used in the multi-year plan.

The Vice-Chair: Can we ask Alison to just clarify that?

Mr Jackson: I support it; I just have difficulty with the specific word that Drummond used. That is all. He is looking for help for that to be sympathetic.

Mr White: Thank you, Mr Jackson. Could it be amended to "organizational infrastructure"? Would that address that?

Mr Jackson: No, I just wanted to use the same word. It does not matter.

Mr Hope: So that we are not brainstorming and creating a lot of smoke, I think there is a direction to Alison to coincide that with the multi-year report.

Ms Drummond: Yes, and to be approved by the sub-committee?

Mr White: Yes.

The Vice-Chair: So we have agreement on that section.

Clerk of the Committee: Except section 4, bullet 2.

The Vice-Chair: Just a minute. I am sorry, within that section?

Mr Jackson: In that section, yes. It was to do with bullet 4, which dealt with the matching funding clause we were working on. What I would request is "funding be restored," not "funding in the field." Again the words "in the field" I do not think are appropriately used there. "Funding be restored to recognize the policy objective of matching funding for placement in the community for both people leaving institutions and for people who are currently being cared for in the community." That was the concept.

The Vice-Chair: Did everyone follow that?

Mr Hope: Could I have Alison repeat that?

Ms Drummond: As I understood Mr Jackson, "Funding be restored to recognize the policy objective of matching funding for placement in the community for both people leaving institutions and for people who are currently being cared for in the community."

The Vice-Chair: Discussion? Agreement? Agreed. Shall we move on? Shall this section carry, except for bullet 2, which we have set aside? Carried. "Advocacy and Protection" section.

Mr Owens: Mr Jackson can think of this as 5 September. The recommendation, bullet 3, we request that be set aside as a contentious issue.

The Vice-Chair: You are setting aside bullet 3 on the section on "Advocacy and Protection" as a contentious issue. Shall the rest of the section carry? That is the appropriate wording? Agreed?

Moving right along to "Training and Human Resources" on page 12, the next section.

Mr White: I am sorry, I have one specific item. The ministry is already funding an advocacy program and there was no representation from that program or the people who were involved in it. I think that is unfortunate. This set of hearings certainly was much more inclusive than the last, but that one omission struck me. We are probably going to be moving to a different advocacy system. However, that is in the future. I think there should be some notation about the problems with the present advocacy system in case we do not move to what is suggested.

The Vice-Chair: Discussion on Mr White's suggestion?

Mr Jackson: Can we have the wording?

The Vice-Chair: Do you have specific wording for that?

Mr White: I do.

Mr Jackson: That would be helpful.

Mr White: This would follow the last agreed upon resolution, so there would be a third bullet.

Mr Jackson: I am lost. What page and what bullet?

Mr White: Page 11, the bullet at the bottom of the page. This would be bullet 3 and it would state: "Unless and until an alternative advocacy system can be instituted, the present adult protective services program should be maintained. The 'housing' of this system should be explored." Presently that system is housed with a number of differing agencies.

The Vice-Chair: Just to be clear, do you have that, Alison?

Ms Drummond: I do.

The Vice-Chair: Could you repeat that again?

Mr White: "Unless and until an alternative advocacy system can be instituted, the present adult protective services program should be maintained. The 'housing' of this system should be explored."

Presently the adult protective service workers are funded 100% by the provincial government. However, they are housed with a number of different agencies. They are housed with public health in some places and with family services in others. In some situations they are entirely on their own with a separate board of directors. So we have a multiple network of funding for these people in their different regions and I am not sure how appropriate it is to have that wide a disparity in terms of the housing organization.

1500

Mr Martin: There is also the question in some areas, and particularly mine, where they are looking at the rationalization of various delivery systems to this population. There is a question of whether the particular service workers should be included in that and by so doing then creating a problem in terms of criticizing or advocating to itself on behalf of whether they should be outside and independent. There is a question there of that and perhaps this is what Drummond is also chasing. It really does need to be

looked at and I am not sure whether it is covered in anything else that is here, but I could support it because in my area that is a problem.

Mrs McLeod: Perhaps I am just confused by the intent of the recommendation. It seems a little bit strange for the opposition side to be asking the government side about a recommendation that seems premised on not continuing with something the government has indicated it intends to do, which is the way I am hearing that recommendation. Quite frankly, I take as a given that the intent of the advocacy announcement is good intent and will be followed up, and that in the meantime the existing system would not be in any way eroded.

Mr White: No, I certainly agree with you. The point here is that I believe all types of service workers have been involved in the consultation processes towards that. My concern is that this is a major program for the developmentally challenged in the community. Perhaps that bullet could be excluded, but I do think there are issues. Let us say, for example, that eventually what is determined is that the advocacy system that is produced through legislation leaves this program alone and separate, then the housing of that program should still perhaps be explored. Regardless, we could leave that out if you wish.

Mr Beer: I understand what Drummond and Tony are speaking about and those are real issues. I do think though, quite frankly, in the wording of the recommendation here, it was a very clear statement by the minister, and indeed even prior, the thinking among ourselves was moving towards resolving that issue. It just seems to me there are a number of other different kinds of advocate groups out there and if we start talking about the one, I just think it can lead to confusion in people reading. My sense is that if as you go through trying to figure how that legislative piece is going to look, there are some holes, none the less those would be dealt with. I am just not sure if this would not make it more complex, because the proposal the minister made in the House, I think, stands on some pretty good research and pretty good agreement among the various players in all the systems.

Mrs McLeod: Just let us know if there are problems.

Mr White: It may not be a necessary addition so suggest withdrawing it.

The Vice-Chair: Mr Owens, did you want to further comment on this?

Mr Owens: Are you still moving forward with the recommendation?

Mr White: No, I am not.

The Chair: I heard Mr White say he is dropping the suggestion. Okay, we are agreed. We will set aside bullet 3 as a contentious issue. We have agreement on the rest of the section. Shall the section carry? Agreed. Page 12 "Training and Human Resources." Discussion?

Mr Jackson: The absence of any reference to the Ministry of Health in any of our recommendations may require its surfacing in bullet 3 and again, in "Co-ordination," bullet 1. It strikes me that we are dealing with health care workers in areas and health programs. I recognize this

s probably an oversight, but I think it would be appropriate for us to get that back in there and place certification standards developed co-operatively.

Maybe there is a role for Health given the health professions legislation review and some of the issues there that we have heard which might again surface in bullet 3 where we are talking about co-ordinating human resources planning. Again, Health should be involved. If we look at long-term care, we know that long-term care is predominantly a Minister of Community and Social Services envelope which will deal with developmental disabilities, so Health could be inserted in bullet 1 and bullet 3.

The Vice-Chair: The Ministry of Health is to be included in bullet 1 and bullet 3. Are there any other items or discussion on this section? Being none, shall this section carry as amended? Agreed

Mr Beer: In the same point?

Mr Jackson: Yes, in bullet 1 under "Co-ordination," I believe Health should clearly be involved.

The Vice-Chair: Okay, so just to be clear, the Ministry of Health should be included in bullet 1 and 3—no, just the one.

Mr Jackson: Just bullet 1 at the moment.

Could I ask if we could get some clarity on bullet 2 in the next section, "Co-ordination"? "The Minister of Community and Social Services become involved in local planning committees as a matter of policy." Local planning committees for what? I just think we might strengthen that if we were a little clearer.

Ms Drummond: I refer that to Mr Beer. That was in the Liberal suggestions before recommendations.

Mr Beer: There was undoubtedly an extremely profound reason why we suggested that and I doubt we would want to change one word.

Mrs McLeod: Whatever it was. That would depend on which point we are talking about.

Mr Beer: We would be pleased to entertain anything that would strengthen the clear intent of that recommendation.

Mr Jackson: I wish to apologize for raising the question.

Mr Beer: I think you should. To be a little more serious here, I think the point was that in a number of places there are local planning committees, but the ministry is not always directly involved, and then what happens sometimes is that you then get something that is developed and a lot of thinking on that goes forward perhaps without the ministry having been aware or involved. Then you get sort of into a whole series of issues where if they were involved from the beginning and as a matter of policy, perhaps some of the planning problems could be avoided.

Mr Hope: If I understand Mr Beer correctly, he is referring to a standard policy throughout the province of Ontario that we follow, in a format, instead of every community going off in its separate way and there is some kind of direction in which we will be going, if I am understanding that clearly.

Mr Beer: I think also we go back to the Children First report and some of the directions around the local bodies that we are looking at in ensuring that they are involved.

Mr Jackson: Could I suggest we look at, "The Ministry of Community and Social Services supporting the development of and participation with local planning committees as a matter of policy." That implies that some are doing it and some are not, and it is a policy statement that we support them, and second, that they participate with. I think that would hit the essence of what Charles is driving at. It is a lot clearer than the way it was.

The Vice-Chair: Okay, we have a suggestion by Mr Owens on that point.

Mr Owens: I agree with Mr Jackson's suggestion. I am getting scared here.

The Vice-Chair: It is frightening.

Mr Beer: Dare I add my agreement as well?

Mr Owens: But I would also like you to include the role of consumer groups within those planning committees.

The Vice-Chair: Mr Jackson, I sense you want to point out—

Mr Jackson: No, it is okay.

The Vice-Chair: Do we have agreement on that, consumer groups?

Mr Owens: Yes, or consumers.

1510

Mr Jackson: The only trouble I have is with form. We have been doing a listing. If you look at the previous recognitions, when we refer to "the groups," we list them. For example, we excluded People First when we listed those people who should participate in consultation. I would assume that everybody understood that they were doing that. I am just simply saying that we have to be very careful because these reports are read in a very literal way, so that if you do not include somebody, they interpret that we did not expect them or want them included. That was only a cautionary note I throw out at the Chair, but it is more a form issue than a substance issue.

Mr Beer: I think that is a good point Cam has made. I think either we are going to have to list them all—we had made that principal point earlier on in terms of the broad consultation, that we want everybody involved. I think in reading this one, the local planning committee, it would be assumed that we want everyone involved, but if we start naming one it suggests then that we are excluding others. We are simply trying to ensure that the ministry be part of that process as well, not apart from it.

Mr White: I am in agreement with that, but I am just wondering a little bit here, suggesting a change in wording a little bit, and that is, "As a matter of policy, the Ministry of Community and Social Services should support the development of local planning committees and participate with them on an ongoing basis." Therefore we are not creating them and leaving them high and dry.

Mr Beer: That is agreeable.

The Vice-Chair: Is that agreeable? It is a further clarification. Alison, do you have that?

Ms Drummond: I am not clear what the decision is on whether to specifically name the consumer groups.

The Vice-Chair: No, we decided not to do that.

Ms Drummond: All right, then that is fine; I have that.

The Vice-Chair: It is Mr White's last suggestion that would be acceptable to everyone in the group. Are you willing to repeat that?

Mr White: "As a matter of policy, the Ministry of Community and Social Services should support the development of local planning committees and participate with them on an ongoing basis."

Mr Hope: I am just starting to wonder if that does not take away from what Mr Beer was trying to clarify in his first opening remarks when he tried to explain—

Mr Beer: My second opening remarks.

Mr Hope: Second opening remarks.

Mr Owens: Whose side are you on?

Mr Hope: No. It is an open committee and I am just trying to get—

Mr Jackson: He is a lot closer to my point of view than you are right now, Steve.

Mr Hope: Again, I am looking at the clarity of it and when I started to understand it at first, it was that we needed direction for all local planning committees to go, and a way of offering information in a policy direction. I just thought maybe it was saying the ministry has to do it, and I think everybody has to do it.

Mr Beer: I think what I liked about the clarification was that the intent was not that there be only sort of one model or no flexibility in how these local planning committees go forward, but simply that the ministry be part of that, and so in that context I thought the direction that Cam went and that Drummond took a little bit further did not take away from that meaning. It still seems to me there is the broad direction, but within that we still want to be able to have the local community have the flexibility to shift things somewhat to meet the particular needs of that community, whether it is in the north or a rural area or downtown Toronto.

Mr Hope: Thanks for the clarity because we seem to be jumping from left to right to left to right and I still was not sure.

The Vice-Chair: We do that quite often around here.

Mr Hope: I am not about to vote for something I am not clear on, and thanks for the clarity on that.

Mr Jackson: Welcome to Queen's Park.

The Vice-Chair: I am sorry. I could not help myself. It is the Chair's prerogative.

Mr Owens: Lions 1, Christians 0.

The Vice-Chair: We have agreement on that. Could you please repeat that?

Mr J. Wilson: I want to go back to point 1 when you are done with this point.

The Vice-Chair: Alison, perhaps you could repeat that so that we all understand what we are agreeing to.

Ms Drummond: The second bullet point now to read, "As a matter of policy, the Ministry of Community and Social Services should support development of local planning committees and participate in them on an ongoing basis."

The Vice-Chair: Agreed? Agreed. Mr Wilson had point to raise.

Mr J. Wilson: Going back to the first recommendation in this section, the intent I see, the way it is worded now, is of course to co-ordinate the ministries. What we have heard from some of the groups was the frustration by parents and handicapped individuals of accessing the system on a number of different points.

If the intent of this point is to co-ordinate, maybe we could say something like—taking it up on the third line—"services provided to the developmentally handicapped, with a view to establishing one point of ministry contact for the developmentally handicapped individuals and their families," the intent being that one of the ministries at some point in the co-ordination process would take it upon itself to actually be the point of contact for families. People were telling us they had to make several phone calls and it is a very confusing system to access.

I am not sure about the exact wording. You could put a period at the end of "for the developmentally handicapped individuals and their families." Then, "This co-ordination should be based on the principle of portable, individualized services," and we do not lose the intent of what is there now.

Mr Beer: Let me just think out loud here for a second. I do not think what we mean is to have one point of access. We are looking at getting the information, but in point of fact there would be multiple points of access. It is not all that dissimilar from last week when we were talking about children's mental health centres. Because that single point of access is a term that is used around long-term care reform, I want us to be careful, because there was an agreement from the witnesses that the multi-year plan should be necessarily within that system. It seemed to me that it was hard getting the information, but depending upon where the individual is in the system he may be accessing it through his family physician, at school, any one of a number of places, and we do not want to be saying that to access the services for the developmentally handicapped there is only one entry. I do not think that is what they were telling us. But is there one place you can go to get the information you need—

Mr J. Wilson: Yes. That is what I was saying.

The Vice-Chair: Do you have any suggestions on the wording?

Mr J. Wilson: Co-ordinated services, the way it is worded now, it is too loose.

Mr Beer: Can you read Jim's again?

Mr J. Wilson: I will make an attempt at it. Taking it in the third line, where it says "services provided for the developmentally handicapped," I had suggested "with a

view to establishing one point of ministry contact for developmentally handicapped individuals and their families." Perhaps we could say "ministry informational"—I was an assistant for years, and it does take half a day to phone all these different things. It would nice if Comsoc, for instance, worked towards setting up a small secretariat where people could phone. Gary mentioned at one time a -800 line. They might work towards that.

Mr Hope: I was just wondering, because we are talking about the community aspect of it, flowing of information, if we could not try to encompass that maybe in point 1, where it talks about developing policy and maybe establishing central contact for information purposes, for instance, somewhere along that line. I am just bouncing words out, but I think at that stage, when you are initially doing the planning, is where you have to develop the communication aspect and how the communications will flow. I think that would be important, that it play a part in that section not somewhere else down the road.

Mr Jackson: We have to be careful here, because we have already in place the Liberal government's initiatives in long-term care and it speaks clearly to the language of co-ordinating five and six ministries to a single window. It also includes the very people we are discussing, because a component for long-term care is the developmentally delayed or disabled who are in nursing homes currently. We already have a one-window framework that the current government is supporting which deals with part of this community, so it strikes me that we want to somehow create a second bullet which acknowledges that a small portion of this community is already benefiting from this government planning and vision and that we hope we would extend the same principle to the entire community of the developmentally disabled.

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That comes at it from the opposite angle, but the principle I would like to support is that we are tearing down a discrimination where, depending on how old you are as a disabled person, you have access as a parent or as an individual to a one-window approach. I would not try to bury the current paragraph, which really wants to talk about portability. That is, if I can steal from the old report, "a bit of emphasis" that we are trying to highlight here.

Mr White: I agree with Mr Wilson that this is a major concern. I think the issue the associations speak about, the prime concern in terms of the problems with funding, is the individualization of services. I think that while he has an excellent point, it is to some degree a major philosophical issue that may require a lot of discussion and hopefully consultation to resolve, which I do not think we will be able to do here. I think this paragraph, as it stands, already addresses some of their major concerns, particularly the individualization issue.

Mr Beer: I have one last suggestion. The question here is around information. I know that during the discussions on the long-term care initiative the community information centres came forward with a number of proposals about information and how it would be made available. For example, in Metropolitan Toronto the community in-

formation centre plays a particular role on weekends around welfare, for example, and other things.

If, in most communities, there is an entity, whether it is called a community information centre or some such thing, is the point here that we want people to have a place where they can go to get information about the system? That might even be a separate bullet which does not necessarily state that it shall be the community information centre, but that community information centres could play a role, or some kind of wording. I know they were looking at that and I just do not know where it went, in terms of some of the information needs that were going to arise out of long-term care.

Mrs McLeod: I think there is very much a difference from the long-term care model our government was proposing, which did involve one-stop access in terms of planning, that there would be a service access organization that would actually do the individualized planning that individual needed as support. When we looked last week at children's mental health services, I was one of the people who felt strongly that you did not want one-stop access for planning for children. You wanted to be able to access a co-ordinated service, but you wanted different points of access to it.

I think this could be either/or in terms of what is the best way to have a co-ordinated program. I guess the point Mr Beer made earlier was that we did not hear any witnesses asking for one-stop access delivery.

Mr J. Wilson: I purposely did not use the word "access," because to me, as both Charles and Lyn have pointed out, that is actually partaking in the service. It was more, as Charles did start out by saying, an informational point. Perhaps we could leave the first bullet intact then, because I think we did hear that they would like to be able to call one number or get information from one source rather than a number of ministries.

Perhaps we could put another bullet in after that which says that the dissemination of service information be co-ordinated through one ministry, to make it easier for developmentally handicapped individuals and their families.

Ms Drummond: May I make a wording suggestion? "That the ministry encourage the establishment"—I would say the Ministry of Community and Social Services—"of a central source of information in each community on the range of services available to the developmentally handicapped." Does that speak to some of the points you want to make?

The Vice-Chair: Is that a helpful suggestion?

Mr J. Wilson: Very helpful.

The Vice-Chair: Does everyone agree with that? Very good. Are there any other points of discussion on the section on co-ordination?

Mr Jackson: Bullet 3: I would like to amend in two locations the recommendation which I had asked for on school boards and the inconsistencies. I would like, "initiate measures including changes in legislation to eliminate inconsistencies between school boards in the access and delivery of programs for individuals with developmental disabilities."

If I may speak to that briefly, school boards will argue that they have the same program; what they have is different rules for access. So they could read it in its current form and argue: "We have the same program. It's just that we're allowing people to access it at different ages and at different points." In my view, its solution is in "legislative changes." I want the discrimination removed between regular day school students and children with developmental disabilities, and that is a legislative change, not a policy change. We already have a policy that says they should not do it, but we know it is happening. I would like to strengthen that as a recommendation in those two areas.

Mr Owens: So the first change is "including changes in legislation"—

Mr Jackson: And then: "to eliminate inconsistencies between school boards in the access and delivery of programs..." It is not the delivery of the program. You can deliver a program and not let anybody into it. I want to make sure they get into it. "Delivery" in legislative terms has come to mean, around here, that it is available, we can do it. "Access" implies that you will be able to get to it. With my background in education, I know how this has been working, and we really need to clean it up with legislation.

The Vice-Chair: Discussion? Is that agreeable?

Ms Drummond: Could I read it out so I am sure I have caught this? It says, "the Ministry of Education initiate measures, including changes in legislation, to eliminate inconsistencies between school boards in the access to and delivery of programs for individuals with developmental disabilities."

The Vice-Chair: Agreed? Agreed. Shall the section, as amended, carry?

Carried. "Legislation" is next.

Mr Beer: Under "Legislation," it seemed to me that there was just one other point we might to reflect. In a number of cases with social legislation, there are different pieces of legislation. For example, we are now working on bringing together the family benefits and general welfare into one act. It seems to me that it would be useful here to indicate, "Legislation should be updated to reflect the principles of the multi-year plan and brought into one piece of legislation," because there are a number of pieces, some that go back, and I think it would be strengthened if we had one piece of legislation. This is the intent. The government may find after exhaustive hearings and so on that there is still a need for some separate piece, but I think what we are trying to indicate here is that having the preamble reflecting the principles and "brought into one piece of legislation" would be the most effective way. I would add those words after the comma at the end of the first line. After the comma, "principles of the multi-year plan and brought into one piece of legislation."

The Vice-Chair: Agreed? Agreed.

1530

Mr Owens: I would like to make an additional amendment to that section; at the end, a new sentence: "Following passage of this legislation, the government

undertake a program of public awareness to facilitate an understanding of the rights of developmentally disabled individuals."

Mr J. Wilson: This is under "Legislation"?

Mr Jackson: A good point. It should be under "Advocacy and Protection." You could expand it, but I do not think it belongs in "Legislation."

Mr J. Wilson: Could you repeat it?

Mr Owens: "Following passage of this legislation, the government undertake a program of public awareness to facilitate an understanding of the rights of developmentally disabled individuals."

The Vice-Chair: It is Mr Jackson's suggestion that we include it under "Advocacy and Protection."

Mr Hope: It deals with the legislation you are creating and developing. I think it is important, as you create and develop, that you explain to the general public. If you were to move it elsewhere, what are you going to explain? It does not give specifics. What you want to explain is the legislative change and possibly the new act.

Mr Jackson: Then eliminate the word "legislation," take that whole existing and the subsequent and put it at the end of "Advocacy and Public Awareness."

Mr Hope: It would take away from the meat of it. If we agree to it, why not just leave it there?

Mr Jackson: It is really not appropriately placed. I personally do not feel the need to let the public know flows from new legislation. I think the need to let the public know flows from the ongoing problem. We have people dying. We have a halt in the plan. There are enough reasons to have a public awareness campaign. I do not wish to suggest that the reason we are going to have public awareness is to broadcast that the government has changed the legislation. The prejudices for the handicapped community exist today and we should get on with the business today. It is a principle of public awareness that should not be tied to a piece of legislation but our ongoing commitment to help the public of Ontario understand the right these people have to community living. That is why. I really do not want to isolate it and say that awareness is a function of legislation. We end up broadcasting the legislation, not the principles of community living, the discrimination we are trying to tear down.

Mr Beer: I understand the point Cam is making. It did seem to me, though, that what Steve was saying was that this legislation, which was going to bring together a number of things and perhaps express them with particular clarity and focus—in that context, it then followed that that being done, the public awareness would flow from that.

It is still a valid point and one that we may want to make just in general, irrespective of legislation, around the point of awareness. But I think that having a special heading on "Legislation" is important, because one of the things we found with the number of pieces of legislation in the social services area is how quickly they can become outdated and the need to really look at that as being an important part of any reform process. I like the way that came together under the heading. If perhaps we want to

nake a further comment about the awareness as of today, when I think we could do that, but I see a certain strength in inking that to the legislation that we are proposing be edone.

Mr Owens: I am hoping we are not going to have to remove this and put it on the contentious issue list. I would agree with Mr Beer, although I do not necessarily want to sit beside him.

Mr Beer: Was it something I did today?

Mr Jackson: I fully support what is stated in the legislation, but my sensitivity to this was developed by Richard Johnston when he first twigged me to the notion that it is wrong to tie the legitimate needs of the community for their ongoing advocacy to a government initiative. History has shown that all governments use it in a self-serving fashion to talk about what the government has done.

That is going to happen anyway. The government will allocate a quarter of a million dollars to sell the public the program. What I am saying is, if the principle is advocacy, then it should stand alone as an investment on the part of his government to help change the mindset of the people of this province and their treatment of developmentally disabled individuals, and not tie it to a piece of legislation which the government will interpret and may not be what the developmentally disabled community says it wants to say to the community at large. I feel very strongly about it. As I say, it was Richard Johnston who first flagged me on his concept and he was spot on. I think he would still be spot on if he were here today.

The Vice-Chair: Perhaps it would be appropriate, then, to ask if this should be set aside if there is disagreement. I will allow a few further comments.

Mr Hope: With all due respect to what Mr Jackson has put by our member previously sitting, I think he had reason to do so. But with the new government, we plan on making sure that proper information is flowed out to the community. I understand why it was flagged that way in previous governments. But we want to move ahead, and I think it would be most appropriate under the special-needs groups, I would firmly support that under the special-needs groups, that the proper advertisement or communication awareness to the public is put in that section also. I would support it to be in both sections.

Mrs McLeod: I thought Mr Owens' point was really quite specific and did not enter into the debate that Mr Jackson has raised at all. I had understood he was recommending that once legislation is created which gives new legal entitlements, we would want people to be aware that there was now essentially a bill of rights. That is quite different from ongoing advocacy, which all of us would support.

Mr Malkowski: Just to follow up with Cam's point, when you were talking about the issue with Richard Johnston, maybe he would give us a bit more of a point of reference on that. I am not clear on what that point was.

The Vice-Chair: Do you really want it?

Mr Jackson: No, it is a legitimate question. It surfaced with Richard and me with respect to changes in child

care legislation. It surfaced with respect to the inordinate number of dollars spent on publicizing wife assault and the women's agenda without publicizing the fact that certain services were not available but certainly explaining what your legal rights were.

He also referenced it again—

Interjection.

Mr Jackson: No, it did not come up on the food banks because it was not a publicity issue. But there was one other. I know which one it was: access and enforcement legislation where there was awareness, dollars to promote a bill. Clearly there was conflict in the community as to how those dollars should be spent and who should be telling the public of Ontario what their real agenda is. I certainly am nervous about any government, whether it is our current federal government, the previous Liberal government or the current NDP government, as to how it interprets what it is doing for us and recommending spending large dollars on publicity.

The Vice-Chair: I do not think you have to worry about the previous Liberal government. It is not elected any more.

Mr Jackson: I want to make it clear I do not make a distinction.

The Vice-Chair: I want to move on to Mr Owens for a final comment, and then I think we have had enough debate on this point and would like to move on after this final comment.

Mr Owens: I am just wondering if we put a bullet point under the issue of advocacy. I do hear what you are saying, but I am still inclined to keep my suggested amendment intact.

The Vice-Chair: Is there agreement on that?

Mr Jackson: We can proceed. I really have strong views. I have shared them. That is sufficient. I just know that it is a sensitive point with me—it is to a lot of people—about how we spend government money to tell people what we are doing for them.

The Vice-Chair: Okay, is there agreement on this section as amended by Mr Owens? Agreed? Carried. Final section: "Special-needs groups."

1540

Mr Hope: In that section, just relating to what Mr Jackson has put forward about the need for public awareness, I think it would be important that we insert something in there about public awareness, because there is still a large percentage of the community that has a hard time accepting people. It is a not-in-my-backyard attitude at times. I think it would be most appropriate that we make sure it is a public awareness issue. I think the public has to be aware of what is happening.

The Vice-Chair: We are talking now about special-needs groups. You are suggesting we put in a new bullet point there?

Mr Hope: Just to try to pick up what has been communicated, I think it would be most appropriate also, and we are getting away from that viewpoint that it is

government and government-manipulated, which it may have been in the past but will not be in the future, that we make sure that the independent source—they will be able to see that communication is equal.

The Vice-Chair: I take that as affirming the amendment, but will I move on to Mr White.

Mr Hope: I was just picking up what you had put forward, but I firmly believe we need precise wording. That is why I tried it as a bullet point.

The Vice-Chair: Perhaps you could think about it. I will move on to Mr White, then if there are any other items—

Mr White: No, I will defer.

The Vice-Chair: Okay, Mr Jackson.

Mr Jackson: To be helpful to Mr Hope, I had indicated that its rightful place in my mind was in advocacy, which is where we placed it. Information is not an issue for a special-needs group. It implies that some of the public knows about it and some does not. I think advocacy is across-the-board awareness. Anyway, I have one further recommendation. I will read it and then answer any questions. "The ministry consider developing the necessary program enhancements with the Ministry of Health to eliminate the flow of funding to US agencies for people with Preador-Willi and establish community-based supports in Ontario."

Is that understood? I will read that again. "The Ministry of Community and Social Services consider developing the necessary program enhancements with the Ministry of Health to eliminate the flow of funding to United States"—and the clerk might suggest a better wording than we have used in the past here, whether we use "American" or whatever—"agencies for people with Preador-Willi" syndrome, if you wish—"and establish community-based supports in Ontario."

Did we get that? I am simply suggesting that they consider the development of these, not that they be done—I am going to make sure you get the operative word, "consider"—with a view to eliminating the flow of funding to the United States.

I have several constituents who are currently being diagnosed and dealt with and supported within Comsoc and Health, but their programs are all in the US. These are becoming a great expense. For a special-needs group, the fact that it was too late to get the Preador-Willi group before the committee—it was referenced by the Head Injury Association and one other brief reference to program dollars that may be utilized in the US—I would feel remiss if I did not present this recommendation at this time. I have watered it down considerably in order to ensure it is understood that we are asking the government simply to consider these programs in the interest of stemming dollars that are currently flowing to the US for these support programs.

For clarification, Preador-Willi is a biologically diagnosed eating disorder which develops within the developmentally disabled community and others that creates a situation of obesity leading to death. There is a supervised element of housing component which is required and the

ministry has recently acknowledged that it fits within the ambit of Comsoc and Health programming, but the program availability is in the United States.

Mr Hope: Just so I get a clearer vision in my head of what Mr Jackson is talking about when he says "people" and referring to numbers of people and the cost value that is slipping out to the United States, if he has some more reference to the material about the flow of people going there, I just need some more clarity in my head, before I vote on something, about whether I think it would be appropriate or not.

Mr Jackson: In the last year, I do not think it is an extensive amount of money, but we are looking at program access for Ontario residents in the nature of about 20 to 25 individuals in this province. It is not these kinds of dollars flowing as are with the problem of how recovery programs and drug abuse programs and solvent abuse programs, but it none the less a program which receives funding to go to the US for the program.

Mr Owens: I am just wondering if I could ask Mr Jackson to explain the ideology and the prognosis of persons with this syndrome, the ideology of the Preador-Willi syndrome and the prognosis that these folks have.

Mr Jackson: The research is in its infancy. It is considered chemical imbalance is the area on which they are now focusing. Its manifestations are obesity and the uncontrolled urge to eat. The elements of community living that require supervision are that they will, for example, go into a restaurant and run up a huge bill and not have the wherewithal to pay for it, and going on binges. It falls between the developmentally disabled community and the mental health community issues, but because there is a supervision component to it, Comsoc seems to be focusing more in terms of delivery programs. The support groups that are now developing around it are through associations for community living.

Mr Owens: With respect to the prognosis, it is something that folks—

Mr Jackson: They do not know, but they have programs in the US, some of which have a chemical and basic component to them and there are some which are counseling and trigger mechanisms for people who then can know what the problem is. I do not wish to get into high-incidence rates among various groups because I do not feel qualified to and I think that would create an unfair image of the disease. It cuts all lines, but I know that the most sensitivity now is being expressed from the Association for Community Living which has several cases of it that it is dealing with.

Mr White: I was just going to comment that I am impressed with Mr Jackson's informed tutelage of us on this particular disorder—I have not personally heard of it; I am not at all familiar with it—and with his concern about the fiscal responsibility of our government. I guess what I was also concerned about was that the kind of program that will be necessitated for the disorder, you mentioned as you clarified it, would be extremely difficult to provide from the local association standpoint. It might in fact be the kind of program that might be able to be offered only

a larger-scale facility. In some sense, addressing that might require a total divergence with the rest of the intent of our report.

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Mr Beer: Are there other programs or are there other ones, different kinds of illnesses, disabilities, whatever the appropriate term would be, like this? I guess the question was just—because I think a number of us do not know that much about this—the way you worded it, I thought, was one that did not say you have to do this and so but to look into it. But if we specifically refer to this, are we leaving any others out or is this the key one that you have heard about?

Mr Jackson: This is the one group that is being caught between the chairs or falling into the crack. When we moved the Head Injury Association agenda forward, one might reasonably argue that they should not be discussed in the general discussion around people with developmental disabilities. Preador-Willi is put clearly within the area of developmental disabilities and it is the one identifying group that I have been able to find which is getting nowhere in terms of program development. That is not to say that these individuals do not need support and assistance in the community. My community is making efforts to assist them for a broader community in Hamilton. Mississauga is in fact where we are trying to develop this in the Burlington area. To answer your question directly, much like the Head Injury Association a decade ago, no one really was talking about them or dealing with them, but in no way did that limit their legitimate right to be dealt with.

Mr Beer: Given the discussion since Cam first read out his recommendation, could you, Alison, just read that back one more time? It is starting to be clearer to me now. Would just like to hear the original recommendation again.

Ms Drummond: Sure. "That the ministry consider developing necessary program enhancements with the Ministry of Health to eliminate the flow of funding to US agencies for people with Preador-Willi syndrome and establish community-based supports in Ontario."

The Vice-Chair: Just for the Chair's clarification, you said eliminate funding for that?

Ms Drummond: To the US.

The Vice-Chair: The flow of funding going to the US.

Mr Beer: Do we want to put in the wording the emphasis on developing the alternatives here? There is always a transition period and I do not know that we want to have an immediate cutoff, but is there some way that that might work, the emphasis on the positive, of the development of the programs here, or whatever? Because you know what can happen is that something gets eliminated, it is not set up here and people are in a worse—

Mr Jackson: Yes. I could even say "to reduce the flow of funding to US agencies." I know the minister is under tremendous pressure to increase the funding for these programs in the US.

Mr Hope: Just to kind of blend, I guess, both concerns into the first stage would be to reduce and then ultimately to eliminate, if that would help.

The Vice-Chair: I think the suggestion was, because I raised this, just a question of cutting things off abruptly, but I will allow further debate on this to see where it is going.

Mr Jackson: Simply, the objective here is to ask the ministry if it would consider developing Ontario-based programs. I am not wedded to the elimination of the flowing of funds to the US. I think it is important that we understand we are not providing the programs here, that we are having to purchase them in the US and that we are basically wanting Preador-Willi to understand that we are hoping we can provide these services here, that they should not have to leave the country in order to get assistance and support.

Mr Owens: I was just going to suggest, with respect to Mr Jackson's last comment, that I do not have a particular problem with the statement as a whole. I am happy he has finally seen the light about stopping the flow of funds to the US, but if we can just take that section out I think that might be a good compromise, if that is acceptable to yourself.

Mr Jackson: Might I ask what part of my political career would lead you to believe that I have come to the light recently on this issue? What was the intent of that statement?

Mr Owens: With respect to your party support of free trade.

Mr Jackson: That has nothing to do with it. I would ask you to be very careful about that.

The Vice-Chair: I think we are getting off topic.

Mr Jackson: Yes, we are very off topic.

The Vice-Chair: I will turn my attention to Mr Beer, who had a point to raise on this.

Mr Beer: In the wording that you are suggesting, with your suggested change, we would not have the part around the eliminating? The emphasis would be on the developing within Ontario.

Mr Owens: Exactly. In consideration of developing program enhancements.

Mr Beer: That is fine.

Mr Jackson: I understand the sensitive word. Just give me the word you want to replace.

Mr Owens: I just want to take out the phrasing, "eliminate funding to US agencies." I think what we are talking about is to get the Ministry of Community and Social Services and the Ministry of Health in consultation to develop programming enhancements. I think that is the issue you are trying to address.

Mr Jackson: I addressed that earlier by saying I could move to the word "reduce." If the elimination was the difficult part, then fine, put in the word "reduce," but I think it is appropriate to note that we do not have the programs, that we are sending people to the US. I do not feel it is fair for any handicapped group to have to go to

the States for its program enhancement or for its program delivery. If that is the contentious word, change it to "reduce."

Mrs McLeod: I just want to add a comment at the end of this discussion. I do not want to interfere with the debate about wording.

The Vice-Chair: I think we are just stuck on terms of wording and emphasis here. Is "reduce" acceptable?

Mrs McLeod: I support the recommendation. I worked very briefly with a Preador-Willi syndrome child so I am sympathetic to the concerns of Mr Jackson, but it does continue a little bit that we are dealing with a recommendation that does not flow from any testimony we had during the course of the hearings. In order to rectify that, I hope that it would be possible to circulate among committee members some information about the Preador-Willi syndrome and the concerns, whether from Mr Jackson or through legislative research, so that as we speak to this report we are all informed about the nature of the problem.

The Vice-Chair: I think that is a very useful suggestion. Perhaps if Mr Jackson has some information, you can offer it.

Mr Jackson: That will be great.

The Vice-Chair: Shall the section on special needs groups, as amended, carry? Carried. We will deal with the contentious items now. Our able clerk reminds me we have an hour and 25 minutes remaining in total. Before we get on with that, Mr Owens has a point.

Mr Owens: I think we need to deal with the narrative of the report, as I would like to add one more contentious issue to the list to be dealt with.

The Vice-Chair: Do you want to deal with the narrative first and then go back to the contentious recommendations, or shall we finish them off?

Mr Jackson: I think we should finish the recommendations because the necessity for a minority report might flow more from the recommendations section than from the narrative. The narrative, quite frankly, is observable events as recorded by the committee. The recommendations are purely negotiated and interpreted matters. So let's get those out of the way. There should not be anything contentious in the narrative.

1600

Mr Beer: Just on a point of information: Are we agreed that we are going to try to complete all of this this afternoon?

Mr Owens: Yes.

The Vice-Chair: We have an hour and 23 minutes now.

It is suggested that we complete the recommendations first. Mr Owens, you wanted to go with the narrative, but I think it is better to do the recommendations as those may take additional time. I am concerned that we get that completed, whereas on the narrative I think there will be easier agreement. It is easier to get consensus on the narrative.

Mr Owens: Yes, let's go.

The Vice-Chair: Bullet point 2 on multi-year plan funding section: "The upcoming provincial budget provide the necessary additional funds to the special services at home program to enable it to be a primary home support option." That is a contentious point.

Mr Owens: One brief comment. Before we discovered what recorded votes were for on the last section, we had made comments with respect to the same recommendation under the children's mental health section. As Mr Jackson corrected me, while it is certainly within the purview of this committee to make recommendations with respect to spending money, I am not sure, however, that I would like to be putting something into a report that I am not completely sure is going to happen. This is why I suggest we vote not to include this particular item.

Mr Jackson: It is hard to comment on what you are struggling with. I can merely state that your rationale can apply to virtually half the recommendations. There is no guarantee that any of this could potentially happen. We attempt as a committee to examine these matters as carefully as possible, to listen as carefully as possible, and the tough part for us is to take all of those opinions and, in some instances where conflicting opinions arise, which we heard—not a lot—we have to make the difficult decision as to what our belief system is.

We have seen that governments have had to deal with very difficult decisions with respect to funding. We recognize that there is more pressure, the fact that the economic climate of the day puts even more pressure on these kinds of decisions. However, the legislative process called us together to examine this and we set out within that mandate to look at whether or not we feel we are committing the necessary dollars. Nothing in this report is binding on the government. It is simply a non-partisan report which is presented to the Legislature in the hope it will stimulate discussion and that, in this hopefully non-partisan forum, we can suggest to the minister that we have come to certain conclusions.

Having said that, I think I personally have attempted to temper some of my recommendations that I feel very strongly about, but I have tempered them in recognition of the economic climate in which we now find ourselves in this province. However, I still feel that on one or two issues they are worthy of the statement that additional dollars may be required, which now brings me to the very focused question, which is tying it to the upcoming provincial budget.

This has traditionally been an area of difficulty, yet I do not think it is as threatening, given that I have asked the minister on both occasions if she has been lobbying the Treasurer and the cabinet, because I fundamentally believe that she supports the principle of getting additional funding.

The fact that she may or may not get it, yes, is in the realm of uncertainty, but I oft-times look at these recommendations as being extremely helpful to a minister of the day, to suggest that there is wide and broadly based support for increased commitments and priorities in this area.

and sometimes it even works as an excellent assist to a minister when she goes forward to see a Treasurer.

I have no difficulty making the recommendation and would suggest that it is less mischievous than it would appear to try and sound. Rather it is in recognition of the fact that everybody agrees we need additional dollars in order to ensure the safety of these individuals and to ensure their rights to access in our community. Therefore, the time for that would be in the upcoming provincial budget, in our view, and I do not think there is as much threatening about that as is being interpreted. I will leave it at that.

Mr Beer: I think a number of the points that Cam has made are good ones to reflect on. Let me perhaps just share with our colleagues in the government party that I can think of a couple of cases where there were committee reports where our members—I mean government members—were recommending some things that I sensed, as a minister, at the very least were going to be very difficult because of the potential financial implications. Yet there was also recognition that, "But look, in the best of all possible worlds, this is really what we would want to do." I am also thinking of the food banks report of this committee last year, and some of the recommendations of the select committee on education.

I know that what happens, both in terms of the bureaucracy and the folks around the minister, is that everybody gets very nervous because obviously if we get to the Treasurer's budget and there are funds for the special services at home program, are they "the necessary additional funds," and what flows from that? I think in terms of what we heard in the testimony before us it was clear that people really emphasized this program and what the committee is saying is, "Look, whatever the dollars are within Community and Social Services, this particular program with respect to the developmentally handicapped is the one to focus on and this is where it should go."

Again, it is a recommendation and neither the government nor a particular minister has to accept it, and I do believe, as a former minister, that we are trying to have committees—and I think in opening the process more—to express some of those views and that there need not be the sense that: "Well, can we do this? What if the minister finds it difficult or the Treasurer is saying, 'Look, there isn't any more money?'"

Based on what we heard and our own discussion, this is the program I think where we would say we would like to put the dollars, and for that reason I think this is a legitimate recommendation which, to the extent possible, I am sure you and the minister and others would like to see implemented. There can still be arguments as to why ultimately that might not be there, or even if additional funds are put in, the opposition in its wisdom can always argue as to how necessary or how additional those were. But it seems to me this can be supported without perhaps causing as many difficulties as sometimes ministers and those around them think it may do.

Mrs McLeod: I just want to second what Mr Beer expressed and add to it a reminder of the testimony we heard from people concerned about the special services at

home program and the fact that there may be a reasonable degree of fiscal accountability in looking at extended funding to strengthen this program, because there is less financial support needed to ensure that those children and/or adults can stay in a home setting than to move into a group home setting. It is an important focus for dollars, I think.

1610

It was also pointed out that the wages for substitute care givers were even lower for the special services at home care givers than they would be in a group home. We have already expressed a concern about the equity of wages between group homes and institutional settings. I just feel it would not do justice to what we heard in this committee if we did not acknowledge that this program needs additional support.

Mr Owens: There is clearly no intention to deny the acute need for money in the system. I understand that all three parties here have a clear understanding of that problem. The witnesses were exceedingly clear on that issue. The problem that I see, again sensing the acuity of need, is tying the government to providing something that may not happen within the next budget process, and I do not think we are saying that obviates the need for money. Again, my only problem is the time line that we are trying to tie the government to.

Mr White: Before I start my discussion of this point, I believe there is a small typographical error at the bottom of page 10 which I would like to be able to come back to at some later time. Could I discuss that now, before Mr Jackson's point?

The Vice-Chair: Is it a small thing? We can just make the correction.

Mr White: I hope so. The special services at home should be regarded as a primary program available to families. This is not a prevention program, as with the children's mental health services. People in the field working with the developmentally challenged often react to the sense of there being a disease that can be prevented. Could that be deleted?

The Vice-Chair: Could I just interrupt and say that if it is agreed to and it is something that we can get over with quickly, then we shall do that without any debate, because otherwise we are jumping into the middle of another—

Mr White: I realize that, but it would be a red flag for that community.

Clerk of the Committee: We have an hour and 10 minutes.

The Vice-Chair: Is that agreed upon on page 10, that we remove the word "prevention" in the last bullet point and get back to the original discussion or debate here?

Mr Jackson: Delete the word "prevention" and just put "primary program available to families"?

The Vice-Chair: Right.

Mr White: It could be "primary support program."

The Vice-Chair: The suggestion was made that we delete the word "prevention."

Mr Beer: But remember that the Ontario Association for Community Living specifically used that wording.

The Vice-Chair: Could we debate that after we finish?

Mr White: At some later point, yes.

The Vice-Chair: On the same point, Mr White.

Mr White: Back to the point we were on, if I could, I want to express my appreciation for Mr Jackson's non-partisan suggestion in regard to this particular bullet, and as well to Mr Beer for his lengthy experience and knowledge of the effect of these recommendations. But with due respect, I want to mention that I believe we are looking at what is referred to as the multi-year plan, not the multi-day plan, and the recommendations which we have are extremely extensive.

In order to incorporate pay equity, adequate funding, training, staff support and develop a program to gauge what is the necessary additional funding for special services at home would require a fair bit of time. The amount of time we would have prior to the provincial Treasurer coming down with a budget would not allow for those kinds of negotiations in terms of pay equity. I think certainly we should be supporting the intent. My concern is simply with the immediacy of this issue.

Mr Beer: To raise another example on this one, perhaps the irony is that at this very moment as we are talking here the Provincial Coalition on Special Services at Home, some of whose members were before us earlier in the week, is speaking to the finance committee on pre-budget consultation. But two years ago, the standing committee on finance and economics made some recommendations around the Social Assistance Review Committee report, about the funding of that, which very definitely had implications for the government and, it is fair to say, caused no end of anguish and discussion among those who were trying to argue how far we could or could not go.

It seems to me that what we are saying here as a committee is that we believe this to be the primary option and we would like to see more money in that program. My colleague Lyn McLeod had noted how that could well save us dollars in terms of other programs. It is ultimately up to the government in its budget deliberations to accept what this committee may say on what the finance committee may say. Often, there are recommendations which, for various reasons, they cannot accept. On the one I am referring to, in terms of the SARC report, the finance committee's recommendations were very specifically on that next budget, because it was the pre-budget consultation. So I think this is not out of line for a committee to do and would really reflect something very important we heard from the witnesses and would urge that we all accept this.

Mr Owens: As a result of the persuasive arguments by the members of the other two parties, I would like to withdraw this as a contentious issue and recommend all-party support.

Mr Hope: I was just going to put forward my support for this. I listened to my colleagues talk about how we can use it to encompass the shopping list and to supply support to the minister. I know it will be on a number of requests

from a number of ministries, and anything that would appropriately help my minister to obtain funding for a viable program of this nature, I would support.

Mr Beer: If they wanted to invite those of us on the opposite side to any meeting of Management Board or Treasury, we would be delighted to go forward.

The Vice-Chair: Do we have agreement on this? Agreed. Shall the section, as amended, carry? Agreed. We move on to "Advocacy and Protection," bullet 3.

Mr Owens: The NDP caucus cannot support this recommendation, as there are currently two ongoing investigations. We cannot conduct investigations on top of legally mandated investigations, such as the coroner's inquest into the Christopher Robin institutions. At such time it is found that an inquiry is needed, the government will be pleased to do that. At no time will there be any effort to conceal any information. As information becomes available, it will be fully and freely shared with all those who request it. It is with that that I restate this caucus cannot support the recommendation.

1620

Mrs McLeod: I would like to concur with Mr Owens that we feel the appropriate investigations into Brantwood and Christopher Robin are being conducted, recognizing in addition that the coroner is involved in the Brantwood investigation. We think one of the concerns that overrides the two specific situations is the issue about the standards of care and the way in which those are monitored on an ongoing basis, which is why we fully support bullet point 1 and feel that this is looking beyond these two situations to ensure that this kind of eventuality is avoided in all similar institutional settings in the future.

Mr Jackson: It is no secret that I feel very strongly about this and certainly would like to put on the record that there is no legal impediment to the suggestion I indicated in the House, that this recommendation flows from a recommendation the current Premier made around nursing home deaths. I feel that vulnerable adults or children, especially those who have died, require the special efforts of people when potential for criminal investigations are at hand. That was a view of the Premier in 1986. It is the view I have in 1991. It is also the view of several of the deputants. I would feel remiss if I did not table it, because of how strongly I believe. The people died. We are, yes, interested in standards of care. That, as Mr Owens has said, is the subject of an inquiry. But to correct Mr Owens in his thinking, in this province's long history only one coroner's inquest has ever resulted in criminal charges. I for one, feel that with those odds there will be in all likelihood no criminal charges.

I do not wish to belabour the point—I would like a recorded vote—but I feel very strongly that had this occurred in an Ontario hospital, any member of the community, with deaths of this magnitude and this number and without that information being shared with the public, there would have been a criminal investigation. I ask for no less for those children who have died. I have called for a recorded vote, and that will be the last I wish to say on this issue.

Mr Hope: With all due respect to Mr Jackson—and I do understand where he comes from, because there were a number of issues in my previous life where I pushed for the same thing—the unfortunate part is that there is a current investigation now taking place. When you have two investigations happening at the same time, there seems to be a battle or a mixture of what is going on.

I feel it is most appropriate, first, that the current investigation be completed, a report filed and if justification—I believe our party is firm, because my Premier has stood on this issue a number of times. If we feel it was unjust or leaned one way, I am sure we would not hesitate to share the information with the members opposite. I am sure we will make sure things are handled in a proper manner that will serve justice to those.

The Vice-Chair: We shall now be voting on bullet point 3, as it stands now. Shall the bullet point be included in that section?

The committee divided on whether point 3 should be included in the report, which was negated on the following vote:

Ayes—2

Mr Jackson, Mr J. Wilson.

Nays—7

Mr Beer, Mr Hope, Ms Haeck, Mr Malkowski, Mr Martin, Mrs McLeod, Mr Owens.

Mr Hope: A point of clarification, Mr Chair: Maybe I am wrong, but do the total recommendations as a whole need to be voted on?

The Vice-Chair: No. We passed each section as we went along.

Mrs McLeod: The issue is the use of the term “prevention” in relation to the special services at home program. I would like to suggest that the word is probably not the most appropriate to describe the purpose, and that the words be “primary home support,” which would be consistent with the wording the coalition for support services at home has just used in its presentation to the finance committee.

The Vice-Chair: Let me get this clear. You want to use “primary support program”?

Mrs McLeod: “Primary home support” is the term the coalition is using.

The Vice-Chair: So you suggest we delete the word “prevention” and use “primary home support program.” Is that understood by all members?

Mr Beer: If members want to look at it, in the presentation they are currently making upstairs, they say: “Recommendation 2: commit to special services at home as a primary home support option for families.” That would seem to be the word. I would accept Drummond’s opinion on that.

Mr Jackson: Just a matter of note, the next bullet puts a dollar figure of \$30 million annualized for a total of \$54 million of additional dollars they are recommending for the budget for fiscal period of 1993-94. Someone was asking how much it might cost.

The Vice-Chair: What we have before us is the deletion of the word “prevention” in the last bullet point on page 10 and the inclusion of “primary home support program.” Shall that amendment be made? Agreed. We move on to the body of the report, page 1, “Introduction.” Any problems with that?

Mr Beer: Just a question on terminology. Can I deal with terminology?

The Vice-Chair: Let’s deal with each section. Standing order 123, is that in agreement? No problems? Carried.

Mrs McLeod: I just wanted to ask whether there should be a reference to the directive to the committee establishing the purpose of the hearings.

Mr Jackson: Would you tell us where it is?

The Vice-Chair: That is open to discussion. That is entirely up to the committee. Mr Jackson, do you have a point to make on that?

Mr Jackson: The same point: Where is the resolution which is the reason we had these hearings?

The Vice-Chair: It is part of the official record. It is not in the body of the report.

Mr Jackson: But when we did the food banks report, it was there.

The Vice-Chair: You want it included in the text.

Mr Jackson: I think it would be good form so that the public, when it reads the report, will know its genesis. Otherwise, they have to get Hansard and find out why we did it.

The Vice-Chair: First, is there agreement that we do that? There is. Where would you like it placed?

Mr Jackson: That is a leading question, if I ever heard one.

1630

Mrs McLeod: There is an indication of the directive of standing order 123. I think it would be appropriate to have a reference to the directive to the committee before getting into terminology.

The Vice-Chair: Somewhere between “standing order 123” and “terminology” we will have that included as a second point? Agreed? Agreed. Next is “Terminology.”

Mr Beer: Terminology in this area is always sensitive. I would find it useful if Gary had any comment on this, but let me just put this forward. This document uses the term “developmentally handicapped.” I can recall one set of discussions where the Advisory Council for Disabled Persons was discussing this and using references to “individuals with developmental handicaps.” I know we can appear to get kind of picky, but the argument was that the term “individuals with developmental handicaps” was placing the emphasis first on the individual as a full human being, if I can put it that way, and then the developmental handicap is almost adjectival or adverbial. While I know that is a little more involved than “developmentally handicapped,” that whole aspect of the sensitivity around how we use words and terminology is one we would like to express here. I just make the suggestion that we might

consider using, "This document uses the expression 'individuals with developmental handicaps' throughout."

Mr Malkowski: "Individuals with developmental handicaps" I think should be replaced by "individuals who are developmentally disabled." "Handicap" has very strong negative connotations, saying, "They can't." But if you look at the disabled, they have a physical disability.

Mr Beer: That would be quite acceptable and I think very helpful.

Mr White: I am a little confused with this terminology, because I know the phrase "developmentally challenged" is often used and I am wondering why there is no reference to that phrase, which is, I would suggest, less pejorative.

Mr Malkowski: "Developmentally challenged" is not acceptable phrasing within the disabled community.

Mr White: I have certainly heard it used by that same community.

Mr J. Wilson: The term "challenged" is usually linked with physically challenged, which is acceptable.

The Vice-Chair: Let me see where we are here.

Mr J. Wilson: I think we have agreement on "developmentally disabled."

The Vice-Chair: Is that agreed? Agreed.

Mr Beer: Sorry, I just want to be clear here. Are we saying this document uses the term "developmentally disabled" or uses the expression "individuals with developmental disabilities?"

Mr Malkowski: Either one would be fine.

The Vice-Chair: To be consistent, I think we should just replace "developmentally handicapped" with "developmentally disabled."

Mr Beer: I would concur with the parliamentary assistant to the minister.

The Vice-Chair: Okay? Agreed.

Mrs McLeod: Do I understand that will be changed throughout the text of the report?

The Vice-Chair: Yes, that is what I was trying to suggest. I am sorry I was not clear.

Mr Jackson: There is now no reference in the report to the term "developmentally handicapped." Do we wish to include that as also being seen as more derogatory? My question is to Mr Malkowski.

The Vice-Chair: Do you really need a discussion on that?

Mr Jackson: I did not ask for a discussion. I wanted his advice on it, because we are not telling people they are not using it; we are just telling them we chose this word. Mr Malkowski shared with us that it was not the best wording but it was better than the other. I am just asking him if he wants us to educate the public that we would like them not to use "handicapped" because it is seen by this committee as being more derogatory. This is an opportunity to clarify that. Otherwise, we are silent.

The Vice-Chair: I guess we need further discussion on this.

Mr Malkowski: I think it would be important for public awareness that we do include it in the report.

Mr Jackson: "'Mentally retarded' and 'developmentally handicapped' or 'mentally handicapped' are now seen to be more derogatory."

Mr J. Wilson: That would be my suggestion.

The Vice-Chair: Okay.

Mr Jackson: Mr Malkowski concurs.

The Vice-Chair: Mr Hope, you had a point on this.

Mr Hope: My point would be that if we change that word, then we are going to have to look at our recommendations.

The Vice-Chair: It would just be changed once in the report.

Mr Hope: Yes, just once, just so that we all know.

The Vice-Chair: Okay, I understand we have agreement to include that. Moving right along then to "Historical Background," are there any difficulties with that section? Shall this section carry? Carried. "Demographic Profile" on page 3.

Mr J. Wilson: On the second bullet there, "26% report," 26% of what?

Ms Drummond: I can clarify that in the body of the report. It is 26% of those 275,000 children mentioned in the previous bullet. I will clarify that.

The Vice-Chair: Agreed? Anything else on that section? Shall the section carry as amended? Carried. Moving right along to "Existing Services" and "Institution-Based." Is there any discussion? If not, shall the section carry?

Mr J. Wilson: It just needs an "s" on it, in the last paragraph, that section.

Ms Drummond: Yes.

The Vice-Chair: Okay, the section on "Community Based," moving right along, is there any discussion? If not, shall the section carry? Carried.

Page 5, "Multi-Year Plan." Discussion? If not, shall that section carry, the first part of it? Agreed. "Co-ordination," under that same section, on page 6. Is there any discussion? Shall the section carry? Carried. Page 7 "Problems and Issues," starting with the auditor's report. Is there any discussion on that section? Shall that section carry? Carried. "Temporary Halt: Multi-Year Plan."

Mr Owens: We object to the inclusion of the final sentence, "A witness also mentioned the perception that OPSEU had influenced the decision (OHIA)." Mr Jackson has characterized this as simply an observable event that took place within the context of our committee hearing. However, we feel that it certainly ought not to be the business of this committee to report unsubstantiated rumours and the witness did in fact state that it was only a rumour. Again, we are not in the business of reporting rumours.

1640

Mrs McLeod: I think I would concur that while clearly the witness did put that in his written testimony, he indicated that was a rumour and perhaps that is not the best piece of his testimony to use in our report. I do think it would be important to reflect the fact that he did make

estimony, and perhaps the issue of the confusion that was created by the temporary freeze on the deinstitutionalization program—the confusion for the reasons behind the freeze—might be a better part of that testimony to include in our report.

Mr Jackson: This section is deficient in so far as the notice of the freeze or the pause in the multi-year plan was a result of a letter from the ministry on 15 November to the Ontario Association for Community Living—that should be a matter of record—and the fact that the freeze was in late November, but in fact it was in the first week of November that the decision was made. The report suggests it was in late November that the halt was put on when we have documented information from Val Gibbons that the halt had been put on during the week of 7 November and was being confirmed. We have the minister's letter.

I believe it should be in the report that concern was expressed that the temporary freeze was announced by OPSEU to its membership on 21 November and that the association was only able to advise its membership on 22 November. Again these are documented items which have been raised in the Legislature and certainly form the basis on which we supported the investigations of this committee.

Mr Owens: Just to comment on Mr Jackson's last statement, in re-reading the request for the hearings under his committee, in no way, shape or form was the issue which was addressed in this final sentence ever mentioned. The issue was around the quality of programming, etc. It had nothing to do with, again, the issue that is addressed within the final sentence of this paragraph.

Mrs McLeod: I would like to support Mr Jackson in introducing some additional material for background. The indication of the temporary halt was also not part of our directive to the committee. With the fact that the lifting of that freeze has been noted, I think the intervening factual information is also appropriate for the record.

Mr Owens: I would also like to object to the entering of information at this point with respect to this issue. If this is the intention you have, to enter your press releases or whatever material you have—

Mr Jackson: No. Your ministry letters while you are the government, I am sure you have no difficulty with that, do you?

The Vice-Chair: Let me just clarify something, Mr Owens. There is no point at which a member cannot introduce material to the committee. That is perfectly within any member's right to do so. At any point in the committee's deliberations, anyone can introduce any information he likes before the committee. Mrs Haeck—or Ms Haeck.

Ms Haeck: Mrs Gannon, but that is okay; Ms Haeck under most circumstances.

The balance is missing entirely from this particular paragraph because the minister herself has stated on a number of occasions in the House, and in fact in front of this forum, that she heard from parents. She definitely mentioned she heard from parents. I feel that really should be reflected in the comments presented here. You have a

substantial portion of the minister's statements that address the reasons for the halt. You do not indicate that in fact the minister had listened to parents.

Mrs McLeod: Mr Chairman, if we begin to expand this by including portions of what the minister or either of the critics or leaders said in the House, we are going to be in for some difficulty in terms of trying to keep an objective record. I think the focus of the committee has been to achieve something constructive, that what Mr Jackson has introduced is a matter of absolutely objective record with documentation. If we were to go beyond that, then I think we would, in fairness, have to go back and include major portions of Hansard over the fall.

Mr Owens: The missing piece in this puzzle is that the minister has cleared up and has clearly set to rest any misapprehension. With all due respect, we are satisfied that the issue has been cleared up. I agree with Mrs McLeod that we have done good work within the context of this committee and it is a little bit of a bitter pill to have to swallow at this point to end on this type of note. Whether Mr Jackson would like to introduce at this point his press releases or letters from the government, as you indicate, Mr Chairman, is clearly within his right. We still cannot support the last sentence in that paragraph.

Mr Jackson: If I may speak to this issue directly, I thought that in the best interests of a unified report we could negotiate down to a simple statement a recorded, documented incident which was discussed publicly in various forums about even the allegations of influence by OPSEU. That, in my view, is an objective observation, and I said it would be misleading and a coverup to avoid completely in the report. In our discussions we had come down to as simple a statement as this and I had hoped we had achieved that. Mr Owens has the right to change his mind or get additional direction and perhaps I was misguided by his authority at the time we were discussing this.

Mr Owens: On a point of privilege, Mr Chairman: I do not think the purpose of the discussion is to question what authority I have within the limits of the subcommittee, and further to that, any suggestion that there was any agreement on my part is clearly misleading, that I had agreed in any way, shape or form to any kind of toning down of the statement. I placed my objections firmly and clearly on the table at the time when the statement was first brought forward.

Mr Jackson: As I recall—

The Vice-Chair: Perhaps we can stick to the main arguments.

Mr Jackson: We will stick to the issue, Mr Chairman. I, for one, have indicated to Mr Owens again in these meetings that we would perhaps not even be having this examination of the multi-year plan had not the nature around the temporary halt been done in such an unusual fashion in this province at that time.

For us to imply that there was never any question that there was no documented evidence, as I have indicated—I do not need to present press releases, Mr Owens. I can present the OPSEU newsletter which openly crows about the issue, that they have obtained a halt. I have also

previously—this is not new—entered into the record the OPSEU memo dated 6 November—I would like that to be on the record—indicating that effective immediately the multi-year had been put on hold.

1650

I am sorry, Mr Owens. This is documented, recorded correspondence which was expressed and exposed to the entire province. I do not have to interpret them. They have stopped. People are not allowed to leave except when their bags are packed. Now there is a copy. Nobody from OPSEU has denied the existence of this letter. The minister regrets, as does the Premier, that it happened, but we cannot abide this report which must be fixed in time in this province's history without there being an understanding that there was some concern expressed out there by all groups.

I have letters demanding resignations, if you want me to get into actual testimony to be presented to this committee. I thought I had tempered it during my questioning. I thought I handled it in a most responsible way, as did the groups. But I think we would do an incredible disservice and I submit we are participating in a coverup if we try to imply that there were not concerns raised about the degree to which OPSEU may have influenced the minister in her decision.

I accept the minister's statement. I am not saying she did not tell the truth. I am saying there were clearly statements made by OPSEU. I have never said in this committee setting exactly what happened, but I am suggesting that I must stick to this principle. It would be unfortunate that a minority report would be called for simply to express my concern that the NDP refuses to acknowledge the existence of the documented evidence which all the deputants were aware of and have, on the record, at some time expressed very serious reservations about it. It will never happen again, Mr Owens, if we have at least recorded it somewhere that it should not, and I am not even asking for that. It will be a minority report if that sentence is taken out to begin with, for God's sake.

Mrs McLeod: I just would like to indicate that I also believe the documented evidence Mr Jackson has proposed entering as some part of the record is as much a part of that record, certainly, as the reference to the minister's statement which appears in the body of this report, and therefore the documented evidence is as relevant to the record as statements from the minister made during the course of the committee hearings.

I think that as we look at a record of what took place at the time of the temporary halt, the documented evidence of what was in fact known at that time is even more relevant than the minister's statement. I cannot concur with Mr Owens that I can take satisfaction from the minister's statement with a retroactive explanation of the reasons for that halt. I was prepared and am prepared to move past that, so that we can deal with a constructive review of the program, and move beyond that so that it does have a constructive outcome, but I would be concerned about censoring a record of what took place at that time.

The Vice-Chair: At this point I am a little concerned that we are going to run out of time very quickly. We have two more speakers on the list and I am going to allow them their say and then I think we should move from there.

Mr White: I am concerned that we seem to be sliding into partisan rhetoric here. I am reminded of Mr Jackson's point that in the report here we are dealing with substantive issues around program delivery and we should be producing a clearly non-partisan directive document. It seems to me that on the halt we are talking about in this debate, I do not have the clarity from these two days of hearings about this particular issue that I think I would need to be able to make a clear decision on this issue. So I have real reservations about having these items included when I am not really clear about them, certainly not from our discussions over Monday and Tuesday.

The second thing I am concerned about is that we are talking about a halt—there seems to be a debate whether it was six weeks, six days, four weeks, whatever—in a multi-year plan and in fact a process which has been ongoing since 1974, some 16 or 17 years. We seem to be giving a great deal of attention to a fairly small aspect of the development of these programs, and this kind of partisan rancour seems really unfortunate given the substantive agreements we have had in these other areas and the importance of proceeding with the report as a whole. It just strikes me as being an unnecessary highlighting of what seems to be an unsubstantiated rumour or whatever, and fail to see that much would be achieved by a continuation of this discussion.

Mrs McLeod: Mr Chairman, I really have to register a concern, after our days of hearings and I think a demonstration on all sides of real concern about this program and about the individuals who are affected by the program, that our indications that we would like the record to be clearly a record of what took place is now being attributed as partisan rhetoric. We were genuinely concerned with what took place and we were genuinely concerned that the only information that was available to us at the time about the reasons for that delay—in fact I would have to amend my statement by saying there really were not reasons given and that was a source of the confusion. It was the source of our concern. One of our witnesses clearly indicated that it continued it to be a source of confusion for people out in the field.

We were very deeply concerned about the lack of consultation prior to the freeze. We were deeply concerned about reasons not being given. We were concerned about the confusion that resulted. I do not think it is fair to suggest that is partisan rhetoric. We were prepared to move past that in this committee, but before us in this preamble is a statement of record. Much of what is here has not been discussed in the two days. It is nevertheless a part of the record and for us it was a genuinely important part of the record because of our concern for those individuals.

Mr Owens: I guess with respect to what Mrs McLeod has said—maybe it was Mr Jackson—about people reading reports and taking them extremely literally

ur concern is that the whole issue may come down to that, when a person reads this report, of course it is going to appear that there has been some collusion between the minister and the union, and to my knowledge and to the knowledge of the minister that has not been demonstrated in the House. It has not been demonstrated anywhere, and again, to report unsubstantiated rumour is clearly not within the mandate of the committee.

Mr Jackson: Have you seen that letter?

Mr Owens: No, I have not, actually.

Mr Jackson: Mr Chairman, to be helpful, perhaps I can share the letter. He said he has never read the 6 November letter from OPSEU.

Mrs McLeod: Mr Chairman, on a point of order—

The Vice-Chair: It is not a point of order. Mr Owens as the floor.

Mr Owens: It is again with those thoughts in mind that we cannot support the inclusion of that last statement in the report.

Mr Beer: Mr Chair, I think what we are talking about here is what is part of the public record and making clear in our report what resulted in calling for this review.

On the record, we have the minister's statement, we have the minister's letter, we have a letter from OPSEU. Is it possible that we put in the middle of that paragraph where it says, "A substantial portion of the minister's statement to the committee addressed the reasons for the halt and for the ongoing review of the multi-year plan," if we then had a sentence, something that noted "material related to this is appended" as part of the report, which would include therefore those public documents that are part of the public record, that have been introduced at different points in the discussion, but where the committee would not be expressing any particular point as to whether this in fact happened or did not happen?

Anybody then reading the record of our deliberations would simply have documents that in fact were part of the public record, and that would include the minister's speech and the two or three other documents that are there. I think we had said then that the last sentence would not be necessary, but it would at least respect the public record. I am wondering if there is some possibility of expressing it that way, which does not mean we get into a long discussion of whether this was correct or not correct but at least have it as part of the public record.

The Vice-Chair: Is there any discussion on Mr Beer's suggestion to make that change? No agreement on that. Okay. Any further debate on this point?

Mr Jackson: It is not a debate; it is a clarification, Mr Chairman. Are the NDP members indicating they are unwilling to acknowledge the fact that the minister informed OPSEU on date X and then informed the association and community on date Y as observable events? Are they not prepared to include that in the narrative explanation of what went on? Oh, no. That is part of what Charles was saying. These are the issues that are—

The Vice-Chair: Sorry, Mr Jackson. I have Mr Hope next on the list.

Mr Hope: Just dealing with documentation which is to be presented, documentation that is not written by the ministry's hands, I would have a hard time, because we are not a governing power. As Mr. Jackson has stated, he has ministry letterhead, or with the deputy minister's signature on it, as being a part of it.

Mr Jackson: You do not believe that the deputy minister can speak for your government. Very interesting.

Mr Hope: With the minister's signature on a piece of documentation, I could understand it being part of it, but to put a piece of OPSEU's newsletter, something we do not have governing power on, I sometimes wonder.

Mrs McLeod: I think the issue is one of reasons offered, understanding in the community at large about the action that was taken, which did give rise to the request for hearings at this committee, and if a letter with the deputy minister's signature on it going out to the community agencies, which was the only piece of information that the community agencies received, is not considered to be acceptable documentation of what took place, then we would have to have the record show that no communication took place with the community agencies, because that is all they received.

The Vice-Chair: One final question. I would just like to remind members that we are quickly running out of time and, Mr Owens, you are going to have to deal with this matter.

Mr Jackson: I was simply going to request that the clock be stopped and that we have a fast five-minute caucus, recess, whatever.

The Vice-Chair: Is that agreed? We will recess for five minutes.

The committee recessed at 1703.

1711

The Vice-Chair: Can we call the meeting back to order? Mr. Owens.

Mr Owens: I would like to revisit the idea that Mr Beer suggested with respect to eliminating the sentence in the "Temporary Halt: Multi-Year Plan" section and to go forward with developing, I guess in a fast manner, some wording that is acceptable to all three parties, if that is acceptable to Mr Jackson.

Mr Jackson: You do not expect me to agree to withdrawing a sentence in support of wording I have not seen nor worked on, so from that simple perspective I could not buy into that one bit. If we are to hold the clock and reconvene tomorrow, then maybe, but I am not prepared to release this sentence under any circumstances. Maybe that will be helpful to the committee.

The Vice-Chair: Would the committee desire a quick recess and then come back?

Mr Owens: Perhaps we can stop the clock, as Mr Jackson has suggested, but continue to work as a group. I think there is mutual agreement that—

The Vice-Chair: No, no. Let me get this clear—

Mr Jackson: That is what I said. I am not prepared to release the sentence, so let's get on with the vote, because I

do not need tonight and tomorrow to work on the dissenting opinion. That is not a threat. It is nothing. I have stated my ground and let's get on with it. That is all. I do not wish to burden this committee further.

The Vice-Chair: I do not think we have agreement, so we must move on. Can we deal with that section, Mr. Beer, before we deal with the matter?

Mr Beer: Did you want to try some wording on that?

The Vice-Chair: We do not have agreement, Mr Beer, in terms of a consensus position. Mr Jackson does not agree with carrying forward with that kind of initiative.

Mr Jackson: To be helpful, I would be prepared to work on wording, but not as a condition of removing that sentence. That is what I thought I heard. I was just being clear.

The Vice-Chair: Mr Owens, is that what the understanding was?

Mr Owens: The two are hinged, that with the acceptance of the wording, the last sentence be removed.

Mr Jackson: That is what I thought.

The Vice-Chair: And you are not prepared to agree with that.

Mr Jackson: No.

The Vice-Chair: That is pretty clear now. Is that clear to everyone? Mr. Hope, one final comment.

Mr Hope: Yes, just one final comment. By putting the so-called documentation that he has and filing it as part of the report, I would see no problem with it. It is public information. But the last line is not one that is justifiable.

The Vice-Chair: We have reached a point where I think we must carry on and I think we will put it to a vote.

Mr Beer: No, I am sorry, Mr Chairman.

The Vice-Chair: Point of order, Mr Beer.

Mr Beer: It is just that there are different things which may or may not be able to happen here. There is some wording that we would like to suggest after that phrase "multi-year plan" which in our view might encompass the concern we have expressed. It may not encompass that which Cam has expressed, but that would obviously then alter it. If we were to have a vote, it would potentially affect that.

The Vice-Chair: Can I remind members that we did have a recess, and if you would like to recess again—if not, I will proceed with the vote, because I do not see a consensus. I am forced to do that.

Mr Beer: Can we have a five-minute recess then in order to see if we can come up with the wording?

The Vice-Chair: If we have consensus to do that, I certainly will accede to the wishes of the committee. Do we have agreement to recess for 5 or 10 minutes? Mr Jackson, is that agreed?

Mr Jackson: To recess for five? Is that what you are asking me?

The Vice-Chair: That is what is being put forward.

Mr Jackson: Sure, no problem.

The Vice-Chair: Okay. Mr Owens, agreed? Recess for five minutes.

The committee recessed at 1715.

1740

The Vice-Chair: I call the meeting back to order.

Mr Owens: Mr Chairman, we are prepared to accept the amended wording, as proposed by the other two parties, that the matter was raised in the Legislature, and we agree that the material that has been presented to this committee by Mr Jackson—which is a 15 November letter to Harry Zwerver signed by Val Gibbons, a memorandum to Ms Nancy Stone, president, Ontario Association for Community Living, as well as a 6 November memorandum sent to the membership over the signature of Nora Anderson from president, OPSEU, Local 117—be appended to the report. While I have not read them in sequential order I would respectfully request that they be entered in sequential order. We also will agree to the withdrawal of the last sentence in "Temporary Halt: Multi-Year Plan."

The Vice-Chair: Is there agreement on what Mr Owens has proposed? Mr Beer, Mrs McLeod?

Mr Beer: Just a point of clarification: Are the wording changes acceptable?

Mr Owens: Yes, they are. We did not put them into the order, but they will appear in the draft report. However the wording that the matter was raised in the Legislature 28 November and 17 December that, "One witness noted that confusion created by the halt continues," is acceptable, and again the withdrawal of the final sentence in that section, "A witness also mentioned the perception that OPSEU had influenced the decision (OHIA)."

The Vice-Chair: Okay. Can I get this clarified for Alison for purposes of rewriting that section to reflect what you just said? Can someone suggest wording then that would be more appropriate?

Mr Beer: Can we stop the clock?

The Vice-Chair: Is there agreement to recess for a couple of minutes?

The committee recessed at 1744.

1748

The Vice-Chair: Order. Can we resume our meeting? Mr Owens, do you have a proposal?

Mr Owens: Alison has the records. I would like to move that the committee accept, as read slowly, so that we can all—

Ms Drummond: Very slowly, and people make noises if I am doing something wrong.

The paragraph will now read: "In early November 1990, a temporary halt on transfers from institutions was placed by the new minister. The matter was raised in the Legislature during question period on November 28. A review of the community services—"

Mrs McLeod: I think you go next to the sentence about the halt. "The halt was lifted the following month and a review."

Ms Drummond: Yes. "The halt was lifted the following month and a review of community services"—

Mr Beer: Available to them.

Ms Drummond: —“available to residents was announced.” “Them” does not seem very clear.

“Material relevant to the imposition of the halt is appended to the report. A substantial portion of the minister’s statement to the committee addressed the reasons for the halt and for the ongoing review of the multi-year plan. One witness noted that confusion created by the halt continues. The review is addressing the question of whether the client who is moved into the community is at risk; if there is, responsibilities are clear; internal and external monitoring is available and whether the client is able to develop to his or her full capacity.”

The Vice-Chair: Agreed, as amended? Shall the section carry, as amended? Carried.

We have nine minutes left, so I would like to get through the rest of the report. “Deinstitutionalization and Lost Savings”? Agreed. “Waiting Lists”? Carried. “Poverty”? Carried. “Benefits and Staffing”? Carried. “Other issues” on page 9? Carried.

Is it agreed that the report be tabled for debate and that the minister respond to the report? Carried.

Clerk of the Committee: The subcommittee will get copies of the document as soon as we can to approve the final changes, either tomorrow or Monday.

Mr Beer: Can I just note that if it is tomorrow, give it to Mrs McLeod, as I will not be here?

Mr Jackson: I just wish to note that at no point have we put on the record those items which are to be appended. As long as that is clear.

Clerk of the Committee: I thought Mr Owens read them.

Mr Jackson: No, they were not read into the record. We were not sitting. The clock was not running at the time it was discussed.

Mr Owens: I would disagree.

Clerk of the Committee: No, he read the names to me.

Mr Owens: I read them into the record.

The Vice-Chair: He referred to specific items, I believe.

Mr Owens: That is right, in sequential order.

The Vice-Chair: Agreed? Okay, so the subcommittee will have a final quick look before it is sent off for translation, before the report is finalized. We are adjourned. Thank you very much, members of the committee.

The committee adjourned at 1754.

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of Ontario**

First Session, 35th Parliament

**Official Report
of Debates
(Hansard)**

Monday 8 April 1991

**Standing committee on
social development**

Deaf Persons' Rights Act, 1990

**Assemblée législative
de l'Ontario**

Première session, 35^e législature

**Journal
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Le lundi 8 avril 1991

**Comité permanent des
affaires sociales**

**Loi de 1990 sur les droits
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 8 April 1991

The committee met at 1542 in room 151.

DEAF PERSONS' RIGHTS ACT, 1990

Resuming consideration of Bill 22, An Act to provide for Certain Rights for Deaf Persons.

The Vice-Chair: I call the meeting to order. Would you please turn to the report of the subcommittee? It is in your file. I would like to begin with that item, in the tabling of the business subcommittee report, and also make note of the fact that I would like—I hope you would like as well—to move to clause-by-clause if there are no differences among us, seeing that we could proceed today and probably conclude today.

Any objections to adopting the subcommittee report? No. If not, then any objections to proceeding to clause-by-clause? If not, then we shall proceed in that fashion. We will turn to Alison for a background presentation on Bill 22.

Ms Drummond: This will be very brief. Actually, "background presentation" is probably a little grand as a term, but in your file you have a memo I prepared with some background material. It consists of just some very general background on what exactly hearing-ear dogs are and training programs for them, which you will hear a lot more about from the witnesses. The third paragraph of the memo addresses legislation in Canada and in the United States.

Today, the library received from an American group, the National Center for Law and the Deaf, some additional information on the housing law that was passed in the United States in 1989 and the Americans with Disabilities Act that was passed last summer. I have that information available if any of the committee members would like to see it. I also have a copy of the legislation passed by the British Columbia Legislature last summer, which addresses all guide animals. That is really all I wanted to address.

The Vice-Chair: Any brief questions to Alison to follow up on that?

Mr Hope: Just one thing dealing with the British Columbia legislation: you say you have that if we request it?

Ms Drummond: Yes.

The Vice-Chair: Any further discussion or questions of Ms Drummond?

HEARING EAR DOGS OF CANADA INC

The Vice-Chair: We shall proceed to our first witness, Jacqueline Harbour, planning director of Hearing Ear Dogs of Canada Inc.

Welcome to our committee. We have 20 minutes for your presentation and, as was decided earlier by all three caucuses, there are three hours available to us for this. We have divided it up evenly, but you can do what you wish with 20 minutes of your time.

Mrs Harbour: Good afternoon. It is a pleasure to be here. Hearing Ear Dogs of Canada started because my mother had lost her hearing as I grew up. It was not until I was an adult that I realized why she was so nervous when I left her alone in the house. She always wanted the dog left with her because, later on I realized, the dog would bark if any one came to the door. If she was expecting a phone call, she always hovered near the phone, and if she was cooking things, she would always stay in the kitchen so that she made sure she could hear the timer she had set.

She was a very nervous, very uptight woman, because she was always worried that she would miss some important sounds. It was not until I was older that I understood why. She was very ashamed of her deafness as I grew up, so as children we did not even know. She covered up, she bluffed and she got through life, but it was a taxing toll on her because she always had to be on guard, always watching people. She learned to read lips by herself. She learned to read body language. So even now, when people speak to her, most people do not realize she is 98% deaf because she picks up on innuendoes, body language. If you point to something, she knows probably what the subject is over there and you would not know she is actually 98% deaf.

My interest in life was dogs. I trained them, I groomed them, I boarded them. I also worked for a veterinarian practice for a number of years and my hobby was training and showing dogs. So when my mother came to Canada, I decided I would train a dog to help her. I figured every time someone comes to the door, the dog always barks, and no matter what you do, you can never stop him, so why could a dog not be trained to respond similarly to other stimuli?

So I trained one of the dogs I used to breed, which is a standard poodle, to alert my mother when somebody comes to the door and then take her to the door. The other thing she wanted was her stove timer, which she uses for many reasons to remind her that she has done something, for instance, putting the kettle on. She would put it on to remind her she had done this or was running a bath or the clothes were in the dryer. The other thing she was always very worried about was, of course, the smoke detector fire alarm. At this time, she could not use the phone, so we did not really train the dog for the phone.

It was so successful and it gave her so much relaxation, other people realized that there was something different in her life. Our local paper, the Hamilton Spectator, was told about it and reported the story. Other deaf people read about it and came to me to train more dogs. I got together with some friends and we established the Hearing Ear Dogs of Canada, and it became incorporated as a non-profit organization. Later on we had the pleasure of becoming involved with the Lions clubs of Canada.

We usually train the dogs to about five or six basic noises, starting off with waking the people up in the morning when the alarm goes off; the telephone; somebody at the door; timers; children crying or a baby crying or somebody calling their names; smoke detectors and fire alarms; and anything else that may be important to the people's lifestyles. The dogs are with the people all the time. They are not pets. They are treated as a working dog or a guide dog so that they go pretty well everywhere with the person. And when people travel, the dogs of course accompany them. And if they have to go into restaurants or travel on public transport the dogs have to accompany them. This is one of the reasons we need the rights protected.

1550

We get our dogs, usually under a year of age, from the SPCA/humane society. It takes about six months to train them, and once they are trained they are placed with the person, which takes about three weeks. Then, after three months we go back and test them to make sure they are working, that the people are keeping up the training that we train the dogs for. Then they are certified, and this is when they are given the bright orange leash and collar that are now internationally recognized, and an identification card that they can either wear or keep in their wallet. If you can imagine a deaf person being accosted because he has entered a mall, he does not know why he is being stopped, he did not hear the person approaching and he has just been scared to death because the person has grabbed him. He also does not know what the person wants because he is talking too fast and probably not looking at him. So showing the identification card explains an awful lot.

We have quite an in-depth application form the people have to fill out. We also want a doctor's report that they are physically capable of caring for a dog, an audiologist's report about their deafness, and some character references. If this is all satisfactory, we then go out and make a personal interview so we can check the people out, see where they live and choose a dog according to their personality, character and lifestyle. Then we train that dog with those particular people in mind. It takes about six months, as I said, to train a dog, and we always keep in constant checkup with them. We make annual checkups, and if they ever need help we are always available.

Some of the things the dogs have done that are almost, you can say, beyond their duty are: one dog saved the life of a lady in a wheelchair. She is deaf but she did live alone. The battery in her wheelchair shorted out and she said she would have been overcome in fumes within about 30 seconds. The dog gave her enough time to fall down and away from the wheelchair and he grabbed her collar and helped pull her out of the kitchen. A deaf single mother was bringing in the shopping and thought she had closed the garden gate behind her and was putting the shopping away and the dog flew in from the garden, ran around and flew back out again. So she immediately followed the dog, got to the garden, the gate was open, she ran out and just caught the little boy before he stepped off the curb into a busy road.

It is very hard to imagine being deaf and not being able to hear these things and recognize them. When one of my

trainers went to place a dog, the lady lived in a trailer park, and when she got there all the lights were off. She thought, is she not there? What is going on? She pulled in and when she got to the door, the lady was waiting for her, and then she switched all the lights on. She said, "Why were you sitting in the dark?" And the lady said: "Because if I did not, I would not hear you, and I would not see you arrive, so you could be knocking on my door for five or 10 minutes and I would not know you were there. This way I see the headlights and I know you have arrived." Whereas as soon as we gave her a dog, she had a much more relaxed and confident life, knowing the dog would hear for her and alert her before she was surprised and scared.

These dogs do give great benefit to the people. One of the scariest things for people who live in apartments is not being able to hear the fire alarm, and this is one of the main things we do train the dogs for in a situation like that, that they do alert the person when there is an alarm. If there are any questions, I would be glad to answer them.

Mr Malkowski: Thanks very much for your presentation. I think it has been a real education for all of us. Why do you feel that a lot of deaf people would prefer to use the dogs over flashing alarm systems? Why do you feel that there is a preference for that? Do you think it is possibly to do with awareness that some people do not know about the flashing systems? What have you found as a reason for preference for the dogs? Have you done any research in that area?

Mrs Harbour: The main preference for the dogs is companionship. Many deaf people are shut-ins, lonely, they are scared to go out now that they have lost their hearing, and the dogs are companions. Also, they give them the confidence to go back out in the community. One lady we know had never met any of her neighbours until she received a dog. Of course she had to take the dog out for a walk; her neighbours stopped to talk to her. So in her whole life she feels more confident, gets out to walk. The big thing is companionship in a lot of cases. And flashing lights do not follow a child around the house. When the child becomes mobile, very often flashing lights miss the fact that they are crying or they have fallen and got into trouble, but the dog will hear them, even when the child is outside playing, maybe in a neighbour's yard. If that child falls down and hurts himself, the dog will alert the parent and tell him and take him to the child.

Mr Malkowski: I know a lot of hearing-ear dogs are requested by people who are deafened, is that correct? That it is often people who have lost their hearing as opposed to people who are born profoundly deaf?

Mrs Harbour: It is about the same amount of people request the dogs.

Mrs Witmer: I really thank you and appreciate the presentation you have made. I would agree with Mr Malkowski, it certainly was informative. What type of dogs are you using for this?

Mrs Harbour: The type of dog we use is usually a small-to-medium-sized dog. There is no particular breed, because we have been able to rescue dogs from the SPCA/humane societies. Many people live in townhouses

and apartments. Therefore we need a small dog, and we have not found any particular breed that suits everyone's purpose. There are also a lot of allergies with deafness and we have to use the poodle in that case. But we have used everything, from the size of a toy poodle up to, as you will see later on, the German shepherd.

Mrs Witmer: What age would an individual have to be before you would supply them with a hearing-ear dog?

Mrs Harbour: We like them to be in their late teens, but we do kind of discourage it because we find when teenagers get to this age there are other things on their minds besides caring for a dog. Their hormones seem to get in their way.

Mrs Witmer: So the use is limited primarily to adults.

Mrs Harbour: Yes. We have placed them with specific individuals of teen age, but it is very specific.

Mr Beer: I was a bit late coming in and Ms Drummond may have answered this question, but in Canada how many organizations are there today such as your own?

Mrs Harbour: There are just two. There is ourselves and the one in British Columbia.

Mr Beer: Okay. So in other provinces this would not exist at all or if it did people would be going down to the States to get the dog or coming to you?

Mrs Harbour: We place the dogs right across Canada.

Mr Beer: Okay. Is it your sense that the demand for this service would grow much more than it is right now if more people—

Mrs Harbour: It is growing in leaps and bounds as the word has spread.

Mr Beer: That's good terminology, given that you are talking about dogs.

Ms Haeck: I must also compliment you on this and your presentation. Reading the information here as well as your presentation, it really puts some life into it. Being a pet owner myself, I can appreciate it. My cats usually, when the doorbell goes, hide underneath furniture as opposed to running towards the door. Have you considered expanding the kinds of animals you train? I know dogs are your particular love, but is there a possibility that you would expand this to other animals?

1600

Mrs Harbour: Are you talking about specifically for hearing?

Ms Haeck: Yes, specifically for hearing.

Mrs Harbour: No, I have never considered that. For other handicaps I can see it, but I cannot really see it as an aid to the deafness.

Ms Haeck: I have seen some news reports where spider monkeys have been used for people who are in wheelchairs. Where there is maybe deafness along with the wheelchair, as you described with the one lady, has any research led you to believe that maybe another animal besides the dog might be useful?

Mrs Harbour: The dog is the most adaptable and it can work where there are the other distractions. The monkeys usually work when it is a one-on-one-only basis.

When people enter that environment, the monkeys are usually put back in the cage. They are extremely mischievous and they copy what people do.

Ms Haeck: Good and bad. Thank you.

The Vice-Chair: Thank you very much. If there are no further questions, thank you for making yourself available and presenting to us today.

Mrs Harbour: You are very welcome.

LIONS FOUNDATION OF CANADA

The Vice-Chair: I call on Ron Brown, executive director, Lions Foundation of Canada. Welcome to the committee, Mr Brown. I would just like to point out, Mr Brown, you have a written brief but unfortunately it is not available to be circulated because we do not have photocopies of it. But it will be made available at the end of our session today, if members would like a copy.

Mr R. Brown: Thank you very much, Mr Chairman. Thank you for giving me the opportunity of addressing this group this afternoon. As was pointed out, I am with the Lions Foundation of Canada. The Lions Foundation of Canada is made up of volunteer members of Lions clubs right across the country. Currently we operate Canine Vision Canada as well as the Hearing Ear Dogs of Canada. I would like to point out that what we are talking about this afternoon is exactly comparable to the rights of a blind person. That is the legislation that is being proposed.

When you talk about the rights of a blind person, I think everybody would agree that that is a very visible situation in that a blind person's dog is in harness, they are on the street, they are very mobile. The situation with the hearing dogs is somewhat the opposite in that their performance is more indoors, it is more in the line of a direct safety feature for a deaf person. Therefore, the public is not as aware as everybody might like them to be of what a hearing dog does. Mrs Harbour pointed out different aspects of the work the dog does for us.

There are, and we recognize it very well, mechanical and visual means for both the deaf and the blind to deal with. The Lions Foundation got involved in this in a very strong way because we felt that yes, there are flashing lights; yes, there are different mechanical means for the deaf and hard-of-hearing people to be made aware of situations. But in doing that, you are also dealing with power failures, you are dealing with batteries going dead, you are dealing with all types of situations. We feel very strongly that the dog guide situation is the most safe and viable situation not only for the deaf but for the blind as well.

I would like to compare it to a situation of a pilot in an airplane. The pilot is not going to let that plane crash, because he is in it, too, and if there is anything at all he can do, he will avoid the crash. A dog is not one bit different. A dog is not going to walk or lead a person into a dangerous situation. They are interested in their own wellbeing as well.

Public awareness is on the rise very strongly with hearing dogs and, as Mrs Harbour said, the demand is getting more and more, and this can be attributed directly to public awareness. What we are finding is that, quite frankly, it is surpassing the demand for seeing-eye dogs when you consider that

the working life of a dog is eight to 10 years and, at that point, that makes the dog 12 years old. With the seeing-eye dogs having been far more in the eye of awareness for the public and the hearing-ear dog really just coming into their own, the demand is becoming very, very high.

I think we should all realize the privilege that we have when we have our hearing and all our faculties. A deaf person would tend to get very lonely sitting waiting for a light to flash or whatever happens, whereas a dog provides them with some companionship as well. That is not the ultimate or the ulterior reason for having a dog, but it is certainly a very major factor.

Mr Chairman, I think at this point I would be prepared to answer any questions in the administration end of it. Mrs Harbour, I think, covered your working aspect of it reasonably well.

Mr Owens: Mr Brown, thank you for that presentation. I think you hit an excellent point in terms of the awareness level. I did not realize that there was a hearing dog out there at all. One recognizes the seeing-eye dogs, as you say, but hearing dogs are something that was totally new to me.

How many applications do you receive on a yearly basis for dogs or for funding?

Mr R. Brown: I would say on the average of 40 to 50 a year right now, whereas when I became involved in 1988, it might have been 20 to 25. It virtually doubled in two years.

Mr Owens: In terms of the kind of difficulties, would the hearing dog be used mainly within the home or used outside the home in terms of going to public places, restaurants and things like that?

Mr R. Brown: If a proper survey was done, the original concept of the hearing dog was basically in the home, but I think they are going into the workplace far more now. The technical equipment that is available in the workplace now has opened up the situation for the handicapped so much more, and the idea of having a dog make a person aware that their phone is ringing or the 10 o'clock coffee break bell has gone or whatever—I think it is becoming more and more commonplace in the workplace.

Mr Malkowski: That is certainly very interesting information you have raised. I think a lot of hearing people do have the idea that deaf people are inherently lonely, which is a common myth among many hearing people. Certainly there are lonely deaf people, but all deaf people are not lonely, just as all hearing people are not lonely—the same proportion, depending on the community. But just for your information, a study has in fact shown that deaf drivers compared to hearing drivers have better driving records, with a lower number of accidents, so deaf people are doing all right. I think that often there are some misconceptions and myths. I am just curious where you have gotten some of that information from. Do you have deaf people involved in the training of the dogs and in awareness and cultural sensitivity issues?

1610

Mr R. Brown: Mr Chairman, can I apologize? I have a little bit of the flu and my head is plugged up tight. I am sorry, I cannot hear the interpreter.

The Vice-Chair: I am sorry. Perhaps Mr Malkowski could summarize, go over, what he had said earlier so it can be repeated a little more loudly.

Mr Malkowski: Sure. I was just commenting on the fact that it is often easy for hearing people to think that deaf people are inherently lonely, which is not the case at all, and it is a common myth. There are deaf people who are lonely and there are hearing people who are lonely, but that is a myth, that all deaf people are lonely, and I was just pointing out that in fact deaf drivers compared to hearing drivers have a better driving record with a lower number of car accidents than hearing people. So I guess one of my questions for you was on some of your information. Do you have deaf people involved in the training of the dogs and providing information and awareness about deafness and cultural sensitivity?

Mr R. Brown: I think a bit of research of some of our clients and some of our applications would reveal that some of these people are alone. I think it is a very definite benefit. I congratulate the person speaking that he is very active in an admirable situation, but I did not mean it as a demeaning remark in any way.

Yes, we have had some deaf people on staff. We use them mainly for training sign language that you are watching happening here. They tend to be a little more harder-working person in that field, because they recognize the value of the hearing dog and they seem to work a little harder with the deaf clients to make it understood.

Ms Haack: I was curious for a bit more information on the placement of the dog. Is it virtually anybody who would come forward who would be interested who would get the dog, or what kind of screening process might you go through in order to determine the best home or best situation for the dog? I mean, this is not a pet. You are probably dealing with need.

Mr R. Brown: When I answer this, I am getting into Mrs Harbour's bailiwick a little more, but there is a definite qualification. Yes, we are interested in the best situation for the dog, but I think our ultimate is to make it a situation where the dog is going to be the most value to a person. That is why I was very cautious to say it is not a companion. It becomes a companion as a result of the work, but that is not a qualification by any stretch of the imagination.

Ms Haack: So you are trying to place the dog really with the greatest need, and you do a series of interviews and have a whole screening process set up to make sure that whatever dog is coming up for placement is going to meet the greatest need.

Mr R. Brown: Yes.

Mr Beer: Any of us who have been involved in the whole series of programs, and I guess I speak as a former Minister of Community and Social Services, in seeing the activities of the various service organizations in our province and indeed in our country—it is amazing the number of things you get involved in in working with and helping people. I think, as part of our proceedings, to say once again thanks to the Lioness for the initiative in this regard and simply note that if we were trying to determine exactly all of the hours that people from various service clubs put

to community and social services, we would probably find that our deficit was twice what it was, and I think this is the appropriate place to say thank you.

Mr R. Brown: I appreciate what you are saying, and it is kind of exciting for us, too, to be involved.

Mrs Witmer: Just following up on what Mr Beer has commented on, the Lions have assumed responsibility. Are they picking up the total cost of the hearing-ear dogs? Or is the individual who receives the dog expected, if he can afford it, to pay some of the cost? Exactly what is happening?

Mr R. Brown: No, the full cost of the training and placing the dog is sponsored. There is no charge to a recipient. Some recipients naturally want to get involved and that is fine, but it is not a prerequisite.

Mrs Witmer: But the expectation is certainly not here.

Mr R. Brown: No.

Mrs Witmer: I would certainly like to echo Mr Beer's comments. I really appreciate the work you are doing.

Mr R. Brown: Thank you.

Mr Malkowski: My understanding is that in one case, the hearing dog was trained and it died. I am just curious, do you have any animal health standards for the dogs?

Mr R. Brown: Oh, yes. It would not be reasonable to expect that we would put out a dog that has health problems. That is going to be a burden on a person rather than a help.

Mr Hope: First of all, thanks for coming. I was just looking over the bill, and Gary beat me to the punch about the qualifications of the dogs themselves and what qualifications or standards would be put in place. You say you do have standards that are in place for those. We know the frustrations the disabled community face within public life with discrimination. Does the bill go far enough to help people take an active part?

Mr R. Brown: I think it does, I think it goes far enough. I do not think we want to be putting ourselves in a situation where there are some unreasonable requests being made by people. I think we are looking at providing some measure of security with the public.

The Vice-Chair: If there are no other questions, I would like to thank Mr Brown for appearing before us.

1620

JILL JOHNSON

The Vice-Chair: We will move on to our next presenter, Jill Johnson. Welcome to our committee.

Mrs Johnson: Can you hear me? I am not too quiet. I cannot hear my voice. Okay.

I have made copies of my last presentation for your reference, as well as the current one for your perusal. It is just being handed out.

Some of you have already met me from my previous presentation, but to others there may be surprise that here is someone, born with a hearing loss, classified as profoundly deaf by medical experts in England and in Canada, who can talk just like you even though this person has an invisible handicap and was integrated in numerous English hearing

schools. My source of communication is lip-reading all the time, unfortunately with limited American sign language.

I was last here on Tuesday, 1 May 1990 and came down by GO train to attend the hearing of the second-day support for the Deaf Persons' Rights Act. While waiting for the GO train to Queen's Park on that particular day, a man came and approached us, making as if to pat Toby. On my refusal for him to pat Toby, I then explained Toby's role as a hearing-ear dog. I thought I was doing extremely well from the bewildered expression on the man's face. Unfortunately, he thought that Toby was deaf, not his owner.

I am again very honoured to be here to present my support for Mr Abel's Bill 22, a reintroduction of private member's Bill 143 by Norah Stoner of the Liberal government—the Deaf Persons' Rights Act based along the same lines to some extent as the Blind Persons' Rights Act. I only played a small part, but I would like to ask for Norah Stoner to be given the recognition of insight for presenting our needs for this act.

I would also like to say thank you to Mr Ruprecht for reading my letter on Toby, alerting to get me out of the house when the smoke alarm went, at the second reading of Bill 22 on 13 December 1990. Thank you very much.

I do not want to produce a repetition of my previous presentations, but would like to reiterate the valuations, if I may use that word, of hearing-ear dogs, not just for me but for all that have these working dogs. I can say without any hesitation that these dogs have opened up our lives from possible seclusion in our homes to socializing within our own communities.

Since having Toby, I myself have become very active in the hearing world in interesting areas of community work, as well as promoting hearing-ear dogs. I enjoy talking to service clubs, schools, and so on, and the educational aspect is very rewarding on both sides. My favourite one of them all was a class of nine- and 10-year-olds at an elementary school. About five children were helping me carry my TTY, brochures, buttons and any other odds and ends that I take with me to promote Hearing Ear Dogs of Canada, and an insight on technical aids available for hearing-impaired people. As we neared my van, a group of children came towards us and I lip-read one child explaining why Toby could not be patted because he was working for me. Asked what was wrong with me, the boy unfortunately had a speech impediment as he proudly told them that I was "death."

Our dogs are with us all the time, following us wherever we go, and it can be pretty infuriating. Our dogs do not just alert us to the everyday noises that the hearing people take for granted. Once bonded with their respective owners, they seem to sense we are special people who need them and start to train themselves to communicate with us in their own special way.

As an explanation, when I told my children to go and clear up all the toys they had left lying around in the basement, about five minutes after this "unfair" request, Toby alerted me to the front door—paper boy for his weekly dues—and then he proceeded to the top of the stairs, looking down in the basement. Toby was telling me something, but not as important as the front door, so I went down to see what the children were doing. I do not remember the reason,

but the children were definitely doing something very bad. If Toby had not communicated himself to me, I would never have found out.

When my family is home, Toby does relax and has a break from his working schedules. If we are all in the same room and the telephone rings, for example, as far as Toby is concerned, he does not have to tell me. The family can hear, so they can now take over the job. But Toby does alert me when the rest of the family are scattered around the house.

Although my children claim unfairness because they cannot get away with murder any more, Toby has enriched our lives more than we realize. He has taken over the responsibilities from my family's shoulders on to his and has given us a taste of freedom from anxiety and concern. My family can go out, leaving me on my own, knowing that the dog will alert me to any strange or familiar noise. The familiar quote in the house right now is: "Ah, forget it. The dog will tell her."

There have been times when accidents could have occurred but did not, specifically where bicycles are concerned. We both enjoy long walks, and unfortunately, children like very long bike rides. Toby places himself in front of me, stopping me from continuing walking until the bikes have gone by.

The independence from human help and some technical aids is beautiful, and no one can really understand that word until it is absolutely experienced. However, one day, I could very well lose that independence and also the other owners with these working dogs. None of us wants to return to a life of dependency on other people or even develop a phobia of not going out in the community again.

I have to be realistic in realizing that I have been very lucky with my upbringing, both education-wise and the ability to speak as a hearing person. That advantage cannot last too long with me as I get older, and I will come and have come across unconscious ignorance, arrogance and insensitivity.

When my children leave home—and there will come a time when I cannot keep my home—I will have problems finding a place that I can call my very own. There are so many places that will not allow pets, even children, in their areas, and one of the handicaps that hearing-ear dogs do face is that there is no act or law to provide them with the same protection as seeing-eye dogs. I can approach the Ontario Human Rights Commission and other ministries knowledgeable about our dogs, but there are no guaranteed protections available for our dogs or even their owners. I would be completely lost without Toby, should his services be stopped through no fault of his own. Seeing-eye and hearing-ear dogs provide the same essential services as well as companionship and loyalty to their owners.

Shortly after having Toby, I was promoting hearing-ear dogs at the Ontario Science Centre, enjoying talking about our dogs and all that is connected with them. Part of the schedule of this particular show was the parade of the breeds, with proud owners showing off their spectacular breed of dogs. The seeing-eye and hearing-ear dogs were at the very end of this parade, partly to educate the public and encourage them to go over to our booths for additional information.

1630

A young girl about nine years of age accompanied by an older lady approached my table. She was very impressed with the work the hearing-ear dogs do, but she also expressed surprise that I was deaf and was amazed at how well I could lip-read and speak. Before she continued on her way, she took one of my hands gently in her hands, patted it and very kindly said: "Never mind. I hope you get your hearing back one day."

But I do have my hearing: My ears are useless, but my hearing-ear dog is valuable. I sincerely hope that we may have your support to pass Bill 22, which would be a very valuable protection not just for us, but for our special hardworking, hearing-ear dogs. Thank you for listening to me.

The Vice-Chair: Thank you. We do have time for questions, so I would ask for questions of members at this time, if there are any.

Mr Malkowski: The time that you did not have the hearing-ear dog, how did you manage in your life? After you received the dog, you noticed that he did help you; you felt more secure?

Mrs Johnson: Absolutely. I would not trade my dog for anything in the world.

Mr Malkowski: I know many deaf people who are not aware of how hearing-ear dogs could help them. Do you feel that we need to provide some kind of education to the deaf community so that they know they could use the dogs for safety reasons?

Mrs Johnson: I think that is a very good idea.

Mr Beer: Within the family—you made references in your presentation to Toby having a pretty strong sense of your children—did you find there was any particular problem when you first got Toby? Is there a problem sometimes when a hearing-ear dog perhaps comes into the family or becoming acclimatized to family life? Was that a fairly easy transition or did you have to work harder on your family than perhaps Toby to understand what his role was?

Mrs Johnson: I do not think I am being realistic in saying no, we did not have problems. We did have problems. I think it was harder on my children, very bad. I have had dogs as pets before. I had to explain that this dog was my dog. I had to feed him, I had to take him out. He was not allowed to go out with them. I really had to explain the difference between a working dog and a pet. I would say a lot depended on the age of the children.

[Interruption]

The Vice-Chair: I believe it is a fire alarm and we should respond accordingly.

The committee recessed at 1635.

1654

The Acting Chair (Mr M. Brown): Welcome back from our little bit of excitement today. Are there further members who have some questions? I have kind of lost track of the list.

Mr Owens: What happened to Joe?

The Acting Chair: Joe has a short attention span. Are there any other members who have questions? If not, thank you very much for coming today. We appreciated your presentation and we most enjoyed it. Thank you very much.

Mrs Johnson: My pleasure, thank you.

NORAH STONER

The Vice-Chair: We were rudely interrupted, and we see that history has repeated itself. I would like to call on my former colleague, Norah Stoner, who is our next presenter, to come forward. Of course this occurred before, when you were in the process of dealing with this bill a year ago. Is that correct?

Mrs Stoner: Yes. That is correct.

The Vice-Chair: Welcome to the committee.

Mrs Stoner: Thanks, Joe. I have never sat in this seat. I sat over where Ms Haeck is, I think, most of the time.

Ms Haeck: I got some of your mail earlier.

Mrs Stoner: Well, I liked it when I was here. I hope you enjoy it, too—a great experience, a real privilege, and it is a privilege to be here. I really appreciate the invitation to come back and to talk about this bill. It is particularly gratifying to see this piece of legislation being revitalized. Some of you may know it was on the order paper the day the House dissolved for the election, and we were going to be the first province in Canada to have hearing-ear dog legislation. Unfortunately, BC has now beaten us to the punch and Nova Scotia is at second reading, so we are playing catch-up. But I am glad we are moving in that direction, and it is really a privilege again to be part of this.

I initiated this bill for a couple of reasons. The first reason was meeting Jill and Toby, and I got to know them through a mutual friend. Jill lives in Ajax and I hired Jill to work in my constituency office. Of course, that meant I hired Toby, too, which was great. And through Jill's work with hearing-ear dogs and with her work in my office, I became very aware of the need for legislation to protect Jill's right to take Toby wherever she wanted to go. Jill could not necessarily be sure of being able to get on that GO train to come to Toronto or to take Toby on any other form of public transportation.

The airlines, for instance, do not all have standard policies of allowing a hearing-ear dog, where they do, of course, allow a seeing-eye dog. Hotels and particularly restaurants hat feel they might be in contravention of the health requirements of the health act are very leery of allowing hearing-ear dogs to have the same kinds of privileges as seeing-eye dogs do, and I think, as was referred to earlier, that there are probably more people now in need of hearing-ear dogs than require the seeing-eye dogs, so the need for legislation is going to escalate at a significant rate in the next little while.

The second reason was that I have a deaf child. Katy is now 19, has other problems besides her deafness. But through her I became aware of the needs of the deaf community. I am a member of the board of the Oshawa Deaf Centre and I am particularly aware of the social isolation. Although Gary, whom I feel I know on a first-name basis, has referred to not all deaf people being lonely—that is true,

but if you think of a person who is deaf from birth, in an isolated community where there are few other deaf people, where the only option of language for a deaf child is signing and there are no other people who sign, other than her or his teacher who commutes on a biweekly basis from Belleville, this is a serious problem and the isolation is significant.

The isolation of a person whose language is only signing is substantial. It was not until Gary got here that there were any facilities for deaf people in this building or throughout Queen's Park, and it has brought a great deal of notice of the requirements of the deaf to the people of Ontario, the fact that he is a part of this Legislature. It is very significant, and with him come his interpreters, and therefore you all see what is essentially an invisible handicap.

The dogs fulfil a social need as well as an alerting need. For those of you who wondered why Toby did not jump up and go nudge Jill when the alarm went off here, the reason was that Toby is aware that there are all kinds of other hearing and speaking people around Jill who could alert her, just as they had alerted her to a telephone at home if there were other people in the room. The dog really does make a difference.

One of the examples of something that Toby did that really amazed me was: Jill was driving her car, with Toby. It started to make a funny noise, but of course Jill was completely unaware of it. But the dog started acting up enough that he persuaded Jill to pull over, only to find that there was a significant mechanical problem with her car that she was completely oblivious to. No flashing light, no alarm system, nothing else other than Toby would be able to do that.

The question Ms Haeck asked earlier about the other kinds of animals, particularly for the people who are physically challenged and unable perhaps to move themselves or lift or carry or that sort of thing, is important. I think that ultimately this province is going to need legislation that will provide for assistance animals for all disabled needing them. That is going to have to be a judgement call between the trainers of the animals and the disabled themselves, and they are going to make their own decisions. But we are going to have to, as a province, provide them with the mechanism so that they can have those animals. I know that dogs are doing the kinds of services that you referred to with the monkeys, not only in peoples' homes, but also outside in the community, allowing people to work, to be involved, to get out and socialize.

1700

So it has made a great deal of difference in Jill's life. She has talked to me about the freedom it has given her personally, but also the freedom it has given her children and her husband, because they are no longer responsible for her. They do not have to think about Mother's response to any given situation, as well as their own response. They are free to just have their own responses and to be able to rest assured that Toby is going to make sure that Jill knows whatever she needs to know, and he does. He does it absolutely magnificently.

That is really my supposedly formal presentation, which is pretty informal. I would be pleased to answer any questions.

Mr Beer: It is nice to have you back here, Norah. I think everyone will understand that some of us would like you to be sitting here.

Mrs Stoner: Actually, Charles, I am not sure that I would really want to.

Mr Beer: There is life after politics.

Mrs Stoner: Yes, there is. It is kind of great.

Mr Beer: In these proceedings it is only fair to note that when our colleague the member for Wentworth North was presenting the bill, and when it was being discussed in the House, he and others noted that you had brought the bill forward in the first instance, and in a sense what we are doing today is saying thank you to a lot of people who helped bring this forward. I know, as you have spoken about it in terms of your own relationship with Jill and with Toby and the stories you told us, that in fact the day you presented the bill the first time, Toby was in the House.

Mrs Stoner: Yes, first dog in the House.

Mr Beer: Yes, first dog, I think.

Mrs Stoner: And Jackie brought her demonstration dog to the House too.

Mr Beer: That is right, and so there have been a number of firsts, and you were noting earlier the fact that Gary has been elected and been in the House and what that has meant, both in real terms and in symbolic terms. I think we are all very much struck by that, how things will change once people come to recognize that there are certain needs people have and that we need to find a way to accommodate those needs.

I was just wondering, in terms of your own experience with Jill working in your office, another dimension; we have talked about the hearing-ear dog this afternoon in the context of being with the family and being with the person. What is the receptivity on the part of the business community to hearing-ear dogs from any discussions you have had? Has that been a problem, or are there just too few people to—

Mrs Stoner: The first reaction is curiosity, and one of the reasons for bringing Jill into the office and giving her responsibilities that brought her out into the community with Toby was so that she could expound on the virtues of hearing-ear dogs and let people know, and it has really made a difference. As a matter of fact, the community of Ajax recently sponsored a walk-a-dog-athon, and that was specifically to raise money for Hearing Ear Dogs of Canada. It was a great event and everybody who had a dog felt they should take it for a walk, anyhow. This way they could get pledges and I would recommend it to other communities. You cannot have Jill, but you can certainly have a walk-a-dog-athon.

It has made a difference, and the business community is now more aware. I mean, we would be out, anywhere, whether it was to a plant, to a restaurant, to any part of our community. There were no doors that were closed, nor should there be. But there could be, and that is the point of the legislation. There could be doors closed and there have been.

We all know of instances that receive a great deal of press where the blind people are forbidden to enter a cab with their animals, or are forbidden to enter a restaurant,

and those people have recourse to the law and they take it. They get a great deal of publicity around it so that more and more people do not make those same mistakes. But the deaf people have no recourse. There is no law for them; there is no protection for their animals. And they need it; they really do need it.

This is the kind of legislation that does not cost the government anything. It does not take a great deal of money to implement it, and yet it will make a difference in peoples' lives. Surely that is what we are all about and that is what we are trying to do.

The Vice-Chair: Any further questions? Mr Hope.

Mr Hope: Just one. My executive assistant is legally blind and his name is Dick Santos. When I start looking at this legislation, I understand what you are looking for, but I also understand in the blind community there is also—you touched on it, about taxicabs and everything else. I understand the limitations of this bill currently as it exists. It is only within certain parameters, it does not go broader, and I am just wondering, is there a way it can go broader? It is nice to put in a small piece of legislation, but there are also a number of other rights that we must address and that is where—

Mrs Stoner: Yes.

Mr Hope: I understand the small move we want to make. It is a very positive move. It is not small and it is small in the sense that there is more we should be doing other than that.

Mrs Stoner: Exactly, but it is sort of a one-small-step scenario, and the first small step the right foot moved when this province enacted the Blind Persons' Rights Act. The second step is the Deaf Persons' Rights Act. Then I would hope that instead of being a private member's bill, that we would be looking in the future to government legislation that would in fact say that the disabled who require assistive dogs should have protective legislation, period, and not get into your definition of disabled, or your definition of the assistive animal, for instance. Those kinds of things are really, as I said earlier, the judgement call of the person who is disabled and the judgement call of those who train the animals and who know what they are able to achieve for a person or not able to achieve.

Yes, absolutely, there should be that. But do not, please, do not stop this bill from becoming law in order for that some-day scenario of the ideal world, because how many years has it been since this was initiated in the first place? It took two or three years to truck through the legislative process last time. So we are another year further down the road and we have more and more people with the animals and more and more people in need of that legislation. Once again, just the process of your member bringing this bill back is heightening the awareness within the deaf community and within the community at large about dogs for the disabled.

1710

Mr Hope: But we have a much broader picture that we have to encompass, and that is all I am trying to say. The legislation is a step—

Mrs Stoner: A very singular step.

Mr Hope: But for the whole disabled community we have major steps that we still have to make, because we have to provide legislation that provides the assistance of dogs, but again, we still have the general public out there that we have to educate on why, how come. For instance: why can a child not pet the dog is one of the major educational grounds in the legislation, those who discriminate against people. Because we all know how long it takes to get through on human rights.

Mrs Stoner: But in the first instance, people needed that level of education about seeing-eye dogs, and although there are still people who are ignorant of the legislation that surrounds them, many, many more of us are aware that those are special animals and their harnesses are the visual symbol that tells us, that alerts us, that the seeing-eye dog is allowed on this bus and that sort of thing. In the hearing-ear dog's case, we need to make people aware that the orange lead and the orange collar and the badge that people sometimes optionally wear are the same kinds of signals. It is going to take legislation to make people aware that they have to respond to those visual signals.

Mrs Witmer: I do not have a question, but I would certainly like to express my appreciation to Norah for her initiative in bringing forth this legislation, and I was really pleased to hear the reasons you did so. Certainly I appreciate that, Norah. Thank you very much.

Mrs Stoner: Thank you.

Mr Malkowski: I want to thank you for coming here. I also think it is a good point that you have talked about making this a government bill as opposed to a private member's, and talking about the expansion of legislation such as that. Is that something you would strongly recommend then, that we expand on this type of bill and that we bring in government legislation to that effect?

Mrs Stoner: I would recommend that this bill before you today receive approval from this committee, and I would hope it would receive approval in third reading in the House. I would, at the same time, concurrently, hope there would be legislation created by the government that would override both the Blind Persons' Rights Act and the Deaf Persons' Rights Act to create a disabled persons' rights act that would cover everybody. But as I said before, please do not make this bill wait for that possibility.

The Vice-Chair: I would like to thank you again, Norah, for appearing before us.

Mrs Stoner: Thanks for the invitation.

The Vice-Chair: You are welcome.

Mrs Stoner: Good luck with it all.

The Vice-Chair: We would like to move rapidly along here. To members of the committee, we do not have any amendments that have been put forward. I would like to call Mr Abel to make a few comments before we proceed with clause-by-clause. Mr Abel, Would you like to come before the committee and make a few comments before we delve into clause-by-clause? Welcome to the committee, Mr Abel.

Mr Abel: Thank you. I was not prepared to speak today. I was under the impression that I was going to speak tomorrow. I came as an observer.

I came at a very good time. I was able to hear Mrs Stoner's thoughts and comments, and without getting into a lot of reiteration, I wholeheartedly support her comments. I do strongly feel that it would be a shame to let this bill just slowly drift away while we wait for an umbrella type of legislation to deal with it. People with hearing problems have been discriminated against for years. I myself have a partial hearing problem and I find it very difficult at times. I just cannot begin to imagine how people who are totally deaf are able to get through without some assistance, that being a hearing-ear dog. Things I have said during the debate in the House, simple things such as a baby crying, a fire alarm, things like that—I think that is all very important. It is long overdue and, yes, perhaps as an interim measure, I think this bill should be passed through the Legislature.

Yes, I too would like to see an expansion on it. Animals have been trained to do things for people with other disabilities and I think it is terrific that we are looking at considering an expansion on the bill. But we need this legislation now and, even if it takes a year for a broader scope or a broader type of legislation to come out, well, at least these people with hearing difficulties have had the benefit of this bill for a year. So that is really all I have to say. I am sorry; I am totally unprepared. As I said, I thought I was going to speak tomorrow, but the sooner we get on with this the better, so thank you for your time.

The Vice-Chair: Thank you, Mr Abel.

Mr Beer: I just think it would be appropriate, Mr Chair, as we are noting that this bill and its predecessor are the result of many people and also different political parties, to just underline again that we are also indebted to the member for Wentworth North, out of his own interest, but also picking up on what a previous member had done. I think sometimes there are a number of things we do around here that demonstrate that kind of collegiality and that this is the place to say thank you to a lot of people. I think the reason we have perhaps brought you here unprepared to speak shows that we all accept the brilliance of what is in the bill and we want to get on with it, as Norah Stoner said earlier, and pass it. Thank you.

The Vice-Chair: If we can proceed and simply say thank you once again for appearing before the committee, Mr Abel. Shall we proceed with clause-by-clause, members of the committee? Bill 22, An Act to provide for Certain Rights for Deaf Persons.

Sections 1 to 7, inclusive, agreed to.

Title agreed to.

Bill ordered to be reported.

The Chair: The bill is now carried and we are thus adjourned until we have further notice. I would like to thank everyone for—this is a model way to participate, despite the fire alarms. Thank you very much, members of the committee. We are adjourned.

The committee adjourned at 1719.

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social development

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de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 10 juin 1991

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Clerk: Lynn Mellor

Président : Elinor Caplan
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 10 June 1991

The committee met at 1546 in room 151.

ORGANIZATION

The Chair: Members of the committee, I call the meeting to order. At this time I want to report on the subcommittee meeting that was held last week, 5 June, proceeding on Bills 43 to 64 on health professions. Everyone is aware of those, I hope. It was agreed that the committee would commence its meetings on Bills 43 to 64 on Tuesday 6 August as follows. I will read out the itinerary.

The week of 6 August: Tuesday, Wednesday, Thursday in Toronto starting at 10 o'clock in the morning and recommencing at 2 pm. The week of 12 August: Monday, Tuesday, Wednesday and Thursday in Toronto again, 10 and 2. The week of 19 August: Monday in Thunder Bay, Tuesday and Wednesday back in Toronto, and Thursday 22 August in London. The week of 26 August: Monday 26 August in Ottawa, Tuesday and Wednesday in Toronto at 0 am and 2 pm, and Thursday 29 August in Sault Ste Marie.

No committees will be scheduled, I believe for research time, the week of 3 September and then there are no caucus retreats that are taking place the week of 9 September. Following that, we come back for another four days of committee hearings the week of 16 September, on Monday, Tuesday, Wednesday and Thursday in Toronto again. That is essentially the plan.

There are a number of other items here to be dealt with following that. These were also agreed to by the subcommittee:

"That Tuesday 6 August be reserved for the ministry and Alan M. Schwartz to speak to the committee; Mr Schwartz was co-ordinator of the health professions legislation review and produced a report entitled *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions*;

"That Thursday 15 August be reserved for unregulated groups and consumer groups;

"That associations representing regulated associations make their presentations in Toronto with a single half-hour presentation addressing both the omnibus and appropriate practitioner's bill;

"That unregulated groups be allowed 15 minutes and individuals be allowed 10 minutes, whether they are appearing in Toronto or out of town;

"That scheduling of out-of-town meetings give preference to unregulated groups and individuals;

"That invitations be sent to persons on the mailing lists submitted to the committee by each caucus, with a cutoff date of Friday 9 August for oral presentations and Friday 30 August to submit written submissions; and

"That an advertisement appear in the daily papers serving the out-of-town locations, informing them of the date, time and place of the meeting."

This is by edict of the clerk.

Mr Owens: You read so well, Joseph.

The Chair: Is that not a great reading? All laughing aside, this was agreed to by the subcommittee. Are there any questions?

Mr Owens: We do have a request. Hopefully, we can do this by consensus. We have allowed 15 minutes for individuals making presentations. I am hoping we can expand that to 30 minutes so they will have the same amount of time the professional groups have.

The second change is that we had talked about and had also agreed that we would not do any advertising, we would just do direct mail to folks who had sent in notices of interest in appearing at the hearings. I would also like to request that we do advertising to get the kind of broad-scope consultation consumers might want to have across the province with respect to these hearings.

As I say, hopefully we can do this by consensus. I realize this is short notice. I did speak with Jim, and, quite honestly, Jim was not all that excited about doing that.

The Chair: Are the advertisements in place of the mailing list?

Mr Owens: No, that is including the lists as well. To do the direct mailing as well as—

The Chair: So you would like to do both?

Mr Owens: That is right.

The Chair: Is there any comment or discussion on the mailing list being mailed as well as advertisements being placed in local papers?

Mr J. Wilson: That was not the comment. We had agreed to put them in local papers in that vicinity. Were you not extending that to province-wide, in addition to the mailing lists? That is my reading of what you said.

Mr Owens: The local papers, definitely, and then the Toronto Star, Globe and Mail, Toronto Sun.

Mr J. Wilson: Province-wide, if not national.

The Chair: Can I just point out that advertising in the daily papers is province-wide. That is standard for all committees—all dailies.

Mr J. Wilson: My understanding from the subcommittee was that we were advertising just in those communities where we were holding—the four corners of Ontario. We were not going province-wide.

Clerk of the Committee: If I understand correctly, originally what the subcommittee had wanted to do was advertise, giving notice to people just of the meetings. I think what Mr Owens is proposing is a province-wide advertisement

soliciting presentations for the committee. Am I correct in my understanding?

Mr Owens: That is right.

Mrs Witmer: I would support that occurring. I think that is important, that all people in the province have the opportunity to be aware of what is going on, rather than just the individuals in the local community where the hearing is taking place, in fairness to all concerned.

Mr Beer: There were a couple of points on the advertising. I think it is important that people be aware so they can prepare submissions, but I wanted to raise a question around the issue of the time. It seems to me that we have, as committees, generally allocated half an hour for groups and 15 minutes or 20 minutes for individuals. I think the reason for that is that often with a group or an organization, certainly with the issues we will be dealing with in these hearings, there are often several people.

I would prefer that we keep to that kind of format; if I understand this correctly, we want to try to ensure that when we are out of Toronto, we are hearing from more individuals in those places. It would seem to me that we would be able to hear from a lot more if we worked the time somewhat differently. The experience with the select committee was that when we did the shorter time frame—5 to 10 minutes in some cases—we got a great deal of participation. My sense would be that we not make the change in terms of the amount of time, but keep it to 15 minutes for individuals and 30 minutes for groups.

Mr J. Wilson: I would like to echo what Mr Beer has just said about the time allocation. I do not think there is any way we are even going to get through the groups that now want to appear before us in the month of August. It was the government's intent from the beginning to have this legislation reported back to the House when it resumes sitting in September. In the government's own interest, to be realistic, the time allocations as set out in the subcommittee report are the best we can do.

Second, on the province-wide advertising, I certainly agree we should hear from as many individuals as possible. I was wondering if the committee would agree that perhaps the advertisement that goes province-wide would invite written submissions. Otherwise, we may be raising the expectation that many other people, in addition to the list we already have, are going to be able to appear before this committee. Given that the list now is some two and a half inches thick, I do not think you can hear all those people in a month.

Mr Hope: We are talking about a blueprint dealing with the health professions of this province. We are talking about province-wide advertising, yet when we come down to reality we are sticking in the large urban areas instead of dealing with rural Ontario, which is going to feel the effects of this legislation more than the larger centres. When I go through this and look at the number of times we are meeting in Toronto, I cannot agree with it for the simple reason that I do not see rural Ontario playing a part in this blueprint.

You may say they can travel to London or they can travel to Thunder Bay. Some of the people who may be

questioning this legislation are perhaps people doing a lot of volunteer time on non-profit boards, and they are not going to have the opportunity of being heard in developing a blueprint for the province without extreme cost. I just think it is more important, if we are talking about province-wide advertisement. I think accessibility also has to be key, making sure accessibility is there for people to make presentations.

The Chair: Can I just comment on that myself? I think it is appropriate and fair to say that the schedule before us attempts to cover the province in each of the corners. As a committee, we have been mandated four weeks altogether—the clerk informs me we still have not had approval for the agenda. Realistically, what you attempt to do in province-wide hearings is to cover the corners of the province. That is all you can hope to do, I think.

Mr Hope: London is far from being a corner of the province. London is in the middle, which is a two-hour drive from Windsor, which is an hour and a half from rural Ontario. That is why I want to put these concerns out.

The Chair: Which part of rural Ontario would we go to, Mr Hope?

Mr Hope: For instance—it happens to be in my riding, unfortunately—Chatham is a central location to southern Ontario which leaves accessibility for Windsor, an hour and a half, and leaves accessibility for London, an hour and a half. If you are talking about accessibility for people, let's talk about accessibility in more legitimate forms.

I was one of the people who used to go quite often to these hearings to make presentations, and it was extremely costly for people from rural Ontario, making sure they had a voice and making sure people heard the effects that legislation was going to have on them.

Ms Haeck: I have to reiterate a similar point. After the select committee on Ontario in Confederation was struck and travelling the province, I received a variety of criticisms from my riding, in my area, that it was felt the Niagara Peninsula was ignored and people really did not feel they had the time and that the distances were too large. Even though Hamilton, for a lot of people, is relatively close on the map, they look at it from the point of view of going to Hamilton from Fort Erie and it becomes a major distance. If we are talking about health-related issues or issues like the Constitution which impact on the entire populace in a very large manner, I think it behooves this committee to look at expanding the locations and expanding the time frame of the committee hearings in the province to really and truly say we are hearing from the people of this province on a very important issue.

1600

Mrs Witmer: I am not averse to the committee going to Chatham, Mr Hope. If that is what you want to do, that is okay with me. We have certainly travelled to Windsor and all over, on occasion, from Kitchener-Waterloo just to make a presentation, and certainly we have to be aware.

I think, though, we also have to be very careful not to become too parochial. Unfortunately, our province is so large that I do not think it is ever going to be fair to all of

the players, so that is something we have to take into consideration.

Getting back to the time, I would support the present allocation of time, the reason being that I had about 20 groups not part of the regulated associations and individuals come and see me in my own constituency office in September. I know those people would very much like to participate, and because I would like to see as many individuals and unregulated groups as possible appear before us, I would suggest that we stay with the 15 minutes and the 10 minutes in order to give everybody an equal opportunity.

Mr Brown: I am a little baffled by the procedure here. There has been a subcommittee meeting of all three parties, and everybody knows the government controls this committee, as it does all committees. It would seem to me that if the government members want to take 15 minutes and go outside and make up their minds about what they want to do and come back in here and tell us, it would simplify all our lives.

I would love to go to Chatham, because that is where my wife studied nursing and I would like to visit again. I would like to go to the other 129 ridings in this province, but obviously there are some time restraints, so I would just implore the government to get its act together and tell us what exactly it wants to do.

The Chair: Mr Brown, you have never been on this committee before.

Mr Brown: True.

The Chair: This has some unique features to it, as you are discovering. We like to build consensus around here, and that is what we are attempting to do.

Interjections.

The Chair: We even have to do it for the government members, while we are at it.

I have three more members on the list. Mr Silipo is next.

Mr Silipo: Actually, I was just going to begin by replying to Mr Brown the same way you have, which is that if he wants us to work it out on this side and just let the rest of the committee members know, we could do that, but we do not prefer to do it that way. This is an important issue which a lot of people out in the province are very interested in. I think it is important that we try to do it in the way that makes most sense to everybody around here and, more important, to the people out there.

The Chair: Could I ask you a question for my own edification? Does that mean party lines will not be upheld in the House as well—consensus-building?

Mr Silipo: We can go into that at other times, Mr Cordiano.

The Chair: I am sorry. There is a little levity here today, so it is the spirit in which we are dealing with it.

Mr Owens: As long as Charlie wins the leadership campaign, there is no problem with that at all.

Mr Silipo: I have a couple of suggestions I will put on the record as well, but it seems that actually there is not that much disagreement in what people are saying.

One thing I had highlighted from this report that caused me to ask some questions was the allocation of time. I think we found, as Mr Beer pointed out, that you can deal effectively in less than 30 minutes with individuals making presentations, but I certainly would agree that groups, whether unregulated, regulated, consumer groups or whatever kind of group, really should be given 30 minutes in order to have an effective presentation.

That would be the suggestion I would make, that in the paragraph that deals with unregulated groups being allowed 15 minutes and individuals 10 minutes, you simply state that all groups or associations be allowed 30 minutes and individuals 15 minutes. I think that would resolve the matter.

The Chair: It does and it does not. I will use my prerogative as the Chair and just point out that it really depends on the House leaders, in terms of the allocation of the total time the committee is given. That is our constraint here. We are working under the parameters that have been given to us by others. It would be wonderful to continue this for two months, and have come before us every group that would like to. I am sure that could be accommodated if your House leader and our House leaders would be willing to do that, but I think that is what we are working with.

Mr Silipo: We need to put together the best proposal we can in terms of what we feel we need as a committee to have this piece of legislation appropriately dealt with. If that requires asking for more hearing time, I think we should do that. It is really that simple, in my view.

The other thing, and I know Mr Beer will respond to this fondly—I say this without pushing it because I will not be here for the hearings as I will be involved in other hearings and other meetings—is that when the committee is sitting, I presume the times set out here basically involve sitting during the daytime. One of the suggestions I would make is that, if you are interested in hearing from consumers and individuals in particular, you might want to look at and schedule some evening sessions. Given that the committee is going to be in and around, whether in Toronto or in other places, that may be one possibility in terms of dealing with the time issue you mentioned.

The other point I wanted to make was more in the line of a question. Is the statement in the report that Thursday 15 August be reserved for unregulated groups and consumer groups a maximum in terms of being the only day that would be reserved for unregulated groups and consumer groups, or is that a day that would be at least a minimum for those groups?

The Chair: I think that is a minimum, but of course that is all subject to revision.

Mr Silipo: If it is a minimum, I am quite comfortable with that.

Mr Owens: As we were talking about consensus-building, we do it brick by brick and granule of mortar by granule of mortar here. My concern is not so much the actual number of minutes people have. I think we all know that this stuff has been around since 1982 and that everybody is going to be organized, from the professionals to the consumer groups. The people we need to get, the people who

have been unheard, are the consumers. My colleague to the right proposed 30 minutes per group and, while I applaud his generosity, considering the workload, I think it may be unreasonable to give 30 minutes to each group. I am wondering whether we should just level it off at 20 minutes per group flat, end of story; that the professionals, the consumer groups, the consumers, everybody gets 20 minutes and that is it.

1610

Mr J. Wilson: I will try to be as kind as I can. Why do we have subcommittee meetings and you guys come in and start debating? Mr Brown made an excellent point, and I welcome him as a member of this committee because he had straight common sense when he brought up the same point. Mr Owens, you should communicate to your caucus colleagues the extent and the numbers of people and groups who already want to come to this committee. Your own House leader mandated the other two parties to have this thing done in a month. Originally, when we got into this, we thought we would go to about December, but your House leader has asked that it be done, and we agreed, with other concessions, to do that.

Second, as for the reason there is 15 minutes for the unregulated groups, you will recall that there are about 75 unregulated groups and I think 24 that will now be regulated contained in these. There are far more groups on the unregulated side. You are going to hear a number of very similar concerns from those groups. It does not take any more than 15 minutes to tell us in a couple of sentences why they feel they should be regulated. We have already met in our caucus with a number of them, and you will find their concerns are very similar, so 15 minutes does give them ample time to state their views for us to consider.

Third, the reason we are in Toronto, and I would ask the clerk to give us a breakdown, is that you will find that most of the groups on the list are from Toronto. In fact, I would venture to say at least 90% of the invitees are from Toronto, and that is some two inches of the list we have to date. If you extend the time, you are not going to be able to get this done in a month.

I disagree with night sittings. My riding is only an hour and a half away, and I am already going to be out of my riding for the whole month of August with the exception of weekends. There are a number of events I must get to after 6 o'clock at night and I cannot afford to be sitting here all night debating this bill, as much as I would like to. That is about what I have to say.

Mr Owens: With respect to night sittings and things like that, I will tread very gently about blocking of things and why we have to go to night sittings. I think the issue here is an equalization of the time. While I appreciate the lecture on communication, I—

Mr J. Wilson: Clearly you have not seen the list. We are only going to hear a few of these every day. There are so many on the list now, it is incredible. You are going to raise expectations and you are going to get the blame as the government.

Mr Owens: What I am talking about is reducing the time for the professionals and the consumer groups. Give

everybody 20 minutes, and then the optics of the situation as we described them earlier are much improved. Whether you have one consumer and 14 professionals wanting to testify I do not think is the issue, but clearly people need the opportunity.

Mr J. Wilson: Can I make one point? The reason they get the half-hour is that they are actually in your legislation, so they need to talk about your legislation line by line. They are actually going to be affected. Your government has already said all these unregulated people are not going to be in. Your minister has, and the ministry for the last nine years, had discussions with all these groups. They need to tell us about the omnibus bill. They need 15 minutes or so to address that, plus they are directly affected by this legislation. I believe they need the full half-hour, because when this committee is done and reports to the House, it is a fait accompli for those people directly affected. So we are talking about two classes of groups, one directly affected and the other that wishes it were affected but which has been ruled out by your government to date.

Mr Owens: No, we are not talking about the people on the wish list. We are looking at individuals.

The Chair: We have been around now almost twice on everybody. There are a few more speakers on the list. We will give them an opportunity.

Mr Owens: I suggest we take a 15-minute recess and come back at 4:30.

The Chair: Is that in agreement? Okay, we are recessed. We come back at 4:30.

The committee recessed at 1615.

1634

The Chair: Members of the committee, we resume our meeting. Can we hear your proposal first, Mr Owens?

Mr Owens: The proposal is simply that, with respect to time limits, we give 20 minutes to professionals, 20 minutes to groups and 10 minutes to individuals, hearing the argument that we want to get through this and understanding, through experience on hearings, that individuals can clearly get out what they need to say in 10 minutes. I think downsizing the other two groups will also help in terms of equalization and fitting these folks in.

It is our understanding from the ministry further that while the list may be long and heavy for potential witnesses, the numbers of witnesses that may be viable is not representative in that pile, and that as we work our way through we are going to find that people have not been active and may not want to testify, and may not be able to pull deputations together in time. While it may seem like a great load, when we actually get down to it, as I say, the total list may not be what we see or what we have seen before us.

Mr Beer: I am just doing a little arithmetic here. I appreciate what you have tried to do, and I think we need to think things through in terms of the 24 acts that deal with those specific groups that will be regulated, Steve. It seems to me that there is one additional level of questioning involved, if you like, for the province-wide professional organizations that are going to be regulated. This

level concerns issues they would want to raise around the specific legislation.

If we still allowed those organizations 30 minutes, and 10 minutes for the unregulated groups and 10 minutes for the individuals, by my calculation that would be about four hours out of the total time. This is the first time this has happened in a long, long time, and I think we do have to make sure, frankly, that half an hour would be spent with those organizations, because this is going to be directly regulating their profession and there may be some points that they feel they need to make.

I would still urge that we consider providing them with 30, and then 20 minutes for the unregulated groups and 10 minutes for individuals. Even with the points you make, I think we could none the less find it difficult where, because of time considerations, the subcommittee has to determine who is going to be able to come before the committee. I know I was under the understanding that the House leaders were looking at perhaps just permitting each committee four weeks instead of five. We show on our list at the present time five weeks. If that is accepted, that is fine, but there could be a further problem.

I would say, given the importance of this legislation, that frankly we should keep that 30 minutes for the province-wide organizations that are in effect going to be regulated specifically by this legislation—I think your point about the 20 minutes for the unregulated groups adds time there—and maintain the 10 minutes for individuals. That would be my approach.

Mrs Witmer: I would agree with the comments that have been made by Mr Beer. If we take a look at the regulations that are coming forward, they do impact on 24 groups. Those people, as a result of this legislation, are going to be tied in; they are going to be regulated by this new bill. They are going to be the ones who are directly impacted. They are also going to be the people who are probably going to go through the bill's line-by-line discussion. They are also the people who are going to be offering the amendments, because this legislation is going to have a tremendous impact on their membership. I would like you to keep that in mind.

These are the people the bills relate to. These are the people who will be impacted. These are the people who will be looking at a line-by-line discussion, and also at making amendments, whereas the unregulated groups will simply not be looking at the actual legislation. They are going to be telling us why they should be included. That is why I would encourage you to give the regulated groups the appropriate opportunity, because they will not be dealing with the legislation on a line-by-line basis or making amendments. They will be telling us why they should be included, and I would encourage you to be very fair and to make sure those people who are going to be bound by this regulation in the future have enough time and enough opportunity to introduce the appropriate amendments. We should make sure that we hear all of their concerns. The other groups are going to have an opportunity in the future to speak to us again, in an attempt to also receive the same advantages, but there is a significant difference when you

are dealing with people who are looking at amendments and line-by-line discussion.

1640

Mr Hope: Just one general comment on some of the things that Mrs Witmer has said dealing with the provincial organizations that will have line-by-line hearings. There was a reference made that there were 24 groups. If we give them all a half hour, that means 12 hours of hearings, and their provincial organization bases are here in Toronto.

Mrs Witmer: That is about two days.

Mr Hope: Okay, you just proved a point. That is it, nothing else.

Mrs Witmer: I would support the 20 minutes, by the way, that Mr Owens had suggested for the unregulated groups.

The Chair: And the professional groups?

Mrs Witmer: I would strongly encourage—

The Chair: Thirty minutes.

Mrs Witmer:—simply because of what I have said, the 30 minutes.

The Chair: I am sorry, just for my clarification, were you also suggesting 15 minutes for individuals?

Mr Beer: Thirty. I was going along with the proposal. It was 30, 20 and 10, I think.

The Chair: So 30, 20 and 10. Okay. Mr Owens?

Mr Beer: His was 20, 20 and 10.

Mr Owens: Mine was 20 and 10.

Mr Beer: Yes, but I am just proposing that it be 30, 20 and 10.

Interjection: See if you can compromise on 15 and 20.

Mr Beer: It seems to me that we have added the five minutes for the unregulated.

Mr Owens: You know, there are two things that we can do. I understand the importance of these hearings and wanting to get as many people out as possible, understanding the significance of this legislation. I am just wondering, in order to get this thing cleared up in a less formal manner, if the subcommittee could meet tomorrow at 3:30. As we are usually scheduled for two days anyway, Mondays and Tuesdays, can the subcommittee get together tomorrow and hash this thing out?

We seem to have one item of contention here, which is time limits. As I said initially, I would like to do this by consensus rather than forcing a vote. I think we all are of the same mind. It is just a matter of process and how we get to that middle point. That is my proposal at this point.

Mr Beer: I appreciate that, but the subcommittee met last week and now we are discussing it, and I think we feel it would be better to do the 30, 20 and 10. As the committee goes about its hearings, there may be some days where, as you say, maybe we do not get as many people coming forward as we thought. But I go back to my colleague's point made earlier, that we must be mindful that this legislation does impact very directly on some 24 province-wide organizations.

I think we want to make sure that the unorganized groups can come forward and set out their points and issues, remembering again that they are going to have other opportunities to make presentations, both to future meetings of this committee and to the proposed commission that would be set up. I just think we need to make sure when we are doing the line-by-line that those organizations most directly affected have the time to provide that.

As I mentioned, if my mathematics are correct, I am talking about roughly four hours in total if each of those 24 does an additional 10 minutes to the 20. We could have all kinds of meetings—I will let the Conservatives speak for themselves—but it seems to me that what we are saying is that we are better to keep it at 30, 20 and 10. If your view is that this is not acceptable, we will have to proceed and call the question.

The Chair: Mr Wilson, would you like to have a say on this? Then we will proceed.

Mr J. Wilson: Fortunately or unfortunately or otherwise, we certainly agree with Mr Beer's comments; no need to repeat them except to say that the Progressive Conservative Party of Ontario and the representatives here do not see what another subcommittee meeting tomorrow would accomplish when we spent an hour and a half—the longest subcommittee meeting I have ever been to—putting down the proposal we have before us.

Just to stress the 30 minutes, if amendments come forward and creative ideas from the groups about to be regulated, we certainly need time also to ask questions, because we will have to consider their amendments very seriously. I cannot see doing that in under 30 minutes.

The Chair: Do I have a motion to bring that forward? Mr Beer?

Mr Beer: We would suggest, and I can move by motion, that we provide 30 minutes to the regulated organizations, 20 minutes to the unregulated and 10 minutes for individuals.

Mr J. Wilson: I will second that motion.

The Chair: I guess we will call for agreement on that. Failing that, we will have a vote. All in agreement? It is unanimous? We are in agreement.

We will proceed on that basis. We will have 30 minutes for regulated groups, 20 minutes for unregulated groups and 10 minutes for individuals.

Mr Owens: What happened to "all against"?

The Chair: I asked if there was unanimous agreement. There was not? Well, then we will have a vote.

All those in favour of Mr Beer's motion? All those against?

Motion negated.

The Chair: Mr Owens moves that we provide 20 minutes, 20 minutes and 10 minutes: 20 minutes for professional groups or associations, 20 minutes for other groups and 10 minutes for individuals.

All those in favour of Mr Owens's motion? All those opposed?

Motion agreed to.

The Chair: Mr Owens, do you have any other items to bring up?

Interjections.

The Chair: Order, please.

Mr Owens: At the risk of causing further consternation to members opposite—

Mr J. Wilson: Give us a raise.

Mr Owens: That is what the Tories are interested in, their raises and their money.

Interjection: And how you spend it.

The Chair: Let's keep it out of points of contention.

Mr Owens: I thought I heard consensus with respect to province-wide advertising. Is that correct?

The Chair: I should probably interpret that myself. I do not believe I did get a consensus on that. Actually, there was no further clarification. But I will turn to Mr Beer and Mrs Witmer. Is that in agreement, province-wide advertising?

Mrs Witmer: We are happy to co-operate with our colleagues.

The Chair: Therefore, it is understood we will have province-wide advertisements in local daily papers.

Any other matters? Have we agreed to the itinerary and the stops we are making?

Mr Owens: In terms of the itinerary, and, of course, subject to the House leaders' approval, as we wind down towards the end, if we, as a committee, feel there are still some areas that have been underrepresented, we should leave the option open to schedule another day of travel or another day of hearings in whatever locale may be appropriate.

1650

Mr Beer: If that is in response to what we get in terms of requests and so on, I have no objection about looking at that. What we may realistically have to consider, though, is taking one of the days here set out and making that change, and hopefully the subcommittee can do that with one voice. Could we take the understanding that this would be our tentative schedule, and we would look at the responses to the advertisements and so on to see whether we want to make any changes? Would that be what you are asking?

The Chair: Did you follow that, Mr Owens?

Mr Owens: If we look at where we could chop, reasonably we might be looking at chopping one of the Metro days; again, depending on the responses. I am just making that as a comment, that if we feel some areas are underrepresented and information may be lacking, we would look at, as we were discussing, chopping a day wherever.

The Chair: I am going to interpret that to mean we can further clarify this some time down the road and get a better indication of what exactly we are going to be doing with the latter part of the agenda.

Mr Beer: But for sort of rough planning purposes, we will take this as a tentative schedule, subject to discussion.

Mr Hope: I am listening to the conversations that are taking place and the arguments that are being put forward. By my calculations of what we will be hearing, I find there

is going to be way too much time spent here in Metropolitan Toronto. We are going to have a lot of free time. For the people of rural Ontario who are going to be impacted by this, I think the committee better take a better look at where they are asking these hearings to be held. It is very important. If you look at taking a total of 12 hours just for the professional groups, that leaves another 11 or 12 days to deal with the Metro Toronto area, and you are forgetting all about rural Ontario. I would just like to make that comment.

The Chair: You have raised that on a previous occasion—

Mr Hope: And I will keep raising it.

The Chair: —and I am sure you will raise it again. It will be duly noted by the members of the subcommittee.

Do I have agreement to adopt the subcommittee's report, with the proposed or discussed amendments?

Report agreed to.

The Chair: Now we have to deal with our budget. It has been circulated. Everyone has a copy.

Mr Silipo: I am moving adoption.

Motion agreed to.

The Chair: I am informed that I need a final authority for the Chair to approve the advertisement copy that will be appearing in the local dailies. Do I have that authority, members of the committee?

Mr Owens: As long as you do not put Mickey Mouse ears or something on the copy.

The Chair: "Yours truly." Agreed?
Agreed to.

The committee adjourned at 1655.

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First Session, 35th Parliament

Official Report of Debates (Hansard)

Tuesday 6 August 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mardi 6 août 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
Greffier : Lynn Mellor

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 6 August 1991

The committee met at 1008 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Étude du projet de loi 43, Loi de 1991 sur les professions de la santé réglementées, et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: Good morning, everyone. I would like to welcome everyone to the standing committee on social development. We are going to be dealing with a package of legislation. The bill numbers are Bills 43 to 64 inclusive. I believe all members of the committee are here. There are a couple of housekeeping items that I would like to mention.

The first is that every committee member has received a package of information. I understand that over the course of the hearings there will be a number of substitutions within the different caucuses. I would ask the whips of each of the caucuses to remind their members to pass the package on to the substituting members, because there will not be additional packages available for every new member of the committee. It is extremely important that the package of information gets passed on, so if all members could ensure that this is available for the person who will be substituting for them, that would be very, very helpful.

This is the beginning of a series of meetings. I want to welcome the Minister of Health here this morning. Today is the day for the Ministry of Health. One of the other housekeeping items is around the availability of scheduled dates. The minister has informed the committee that she will not be available the week of September 16 for clause-by-clause discussion as had originally been anticipated, so we should think about that time commitment.

Hon Ms Lankin: Madam Chair, if I might speak to that point, I know that you have given some contemplation to having Mr Schwartz—

The Chair: He is available on the 16th.

Hon Ms Lankin: On the 16th. I certainly have no objection to the committee proceeding with a date with Mr Schwartz, and then we could pick up in another appropriate week on the clause-by-clause. I will make sure I have people here and available. I just personally will not be able to attend that.

The Chair: One of the housekeeping items for the committee is to determine whether it would like to hear from Mr Schwartz on September 16 even though the minister will be unavailable, as we had originally planned that week

for clause-by-clause. I have two heads nodding—three. Is it the consensus of the committee to invite Mr Schwartz to appear on September 16? Yes? Agreed? Any objections?

We will advise the clerk to invite Mr Alan Schwartz to appear before the committee on September 16 for the day to make a submission and answer questions of committee members. We will then await the direction from the minister regarding timing for clause-by-clause discussions. Is that acceptable?

Hon Ms Lankin: That is fine. I believe there was an alternative week that had been discussed and that is fine with our office.

The Chair: Just a second, I want to confer with the clerk. For the information of the public, as well as those who have an interest in this package of legislation, the clerk has informed me that clause-by-clause will likely be dealt with once the House resumes in the fall, following September 23, on Mondays and Tuesdays through the fall session of the Legislature. I will direct the clerk to establish meeting dates and times in conjunction with the whips of the three caucuses, but that will be the assumption for clause-by-clause on these bills unless I hear any objection or direction from anyone. Agreed?

Mr Beer: Agreed, Madam Chair. Just so I understand, we would probably then meet with the minister beginning the 23rd? The minister made reference to another set of dates for clause-by-clause.

The Chair: That was the set of dates that had been discussed. Unless there is any change and unless otherwise notified, we will assume it will begin the week of the 23rd.

This is, as I say, the first session. Are there any questions or comments that any of the members of the committee would like to make regarding procedures? Certain decisions were taken by the committee, and I would just like to confirm at this time that normal procedures of standing committees plus the decisions taken by the full committee are clearly understood by everyone, and that it is the job of the Chair to see those procedures are enforced. We will begin.

MINISTRY OF HEALTH

Hon Ms Lankin: Good morning to the members of the committee. I will just take a moment to introduce Linda Bohnen and Alan Burrows from the ministry. They are much better versed on this legislation because they have had many years of history in working on it and will be spending most of the day with you answering some of your questions.

I want to take some time at the beginning, however, to talk about what our intent is with respect to this legislation: what we hope to accomplish by it and some of the draft amendments I will be submitting to you today to let you know where we think we may be going with some of the clauses. As well, I wanted to alert you to some of the areas that I expect you will hear some very strong representations

on and that I will ask you particularly to look at, because we are struggling ourselves within the ministry with what sorts of amendments we may be looking at for those areas. I truly hope to be guided by the work of this committee.

I think it is important to note that we have arrived at a point in this legislative process where this legislation, the Regulated Health Professions Act, will get a fresh look. In the sense of the legislative agenda, it is the final look that this legislation will get before we go to third reading.

As a package, it has been on a long road, and sometimes it could be described as a bumpy road. It has been eight years that there has been an attempt to bring forward this package of legislation. We may all be taking part in a very historic moment when third reading happens, following that proclamation. I have to again, as I did during second reading, pay tribute to the Chair of your committee, who as a former Minister of Health spent a great deal of her time and energy shepherding this piece of legislation through for introduction. We are hopeful that this fall session will see it come to fruition.

We believe that over the years, the Health Professions Legislation Review that took place and the recommendations it has made have for the most part been maintained intact in the legislative packages that you will be looking at through the course of your hearings. We believe it still is open to amendment, however, in that over a long period of time a lot of people have had very strong representations to make about this legislation. Many people feel there are ways in which the intentions of the bill can be better achieved, or the underlying policy objectives of this legislation can be better achieved. I know the committee will have its work cut out for it in order to review all of those submissions and to make sense of the package as an entire entity. I think it is important that this balance be given in your approach as you look at it.

There are people who will make submissions either to make known the opinions of professional or interest groups that they represent or to make known their own opinions as concerned consumers. You will have in front of you the task of conducting the public hearings, hearing from these presenters, and then reviewing the legislation clause by clause, taking into consideration all of the submissions you have heard. Finally, you will make your recommendations for changes to the legislation for the Legislature to vote on.

I am anxious to receive those recommendations that you will offer. At the ministry we are still considering proposed amendments and are developing others that we have in mind. I have with me today a number of draft amendments to the Regulated Health Professions Act and the Health Professions Procedural Code and the health professions acts, and I will ask you to consider them. I will distribute them to you later. These are proposed amendments that reflect our current thinking. I consider them to be subject to what is heard here at committee, so these are not being officially proposed as the official government amendments at this point in time. I look for your comments on those.

We thought it important that you be aware of where our thinking is headed, and in particular that members of those interest groups out there, many of the professions

themselves, be aware. Some of these amendments are in areas that people have been lobbying for, and if we are thinking of going in that direction, we thought it fair that they have that knowledge before coming before the committee in terms of using their scarce time to focus on the areas where they think perhaps the ministry has not heard their message. So we are hopeful that the proposed draft amendments will be of assistance to you in your work and of assistance to the groups.

There will, however, be professional groups who will continue to have concerns about legal and procedural provisions within the legislation. Others will have concerns about things like scopes of practice and authorized acts. I am sure you will hear from some groups a desire to see the harm or basket clause reinserted into the legislation. I am not proposing that this be done at this point in time. We believe the 13 controlled acts provide ample protection for consumers and we have not been convinced otherwise. However, those concerns will come forward and this is the place for those voices to be heard. That is the purpose for this kind of a public forum. I look forward to your deliberations on that point and others.

I am very pleased to say that the level of interest in making submissions to this committee on this legislation is very high. In most of the cities where the hearings will be conducted, Toronto, London, Ottawa, Thunder Bay and Sault Ste Marie, the response has been very gratifying, and in fact we are booked up completely in some areas. I think that speaks to the process you will be undertaking and to the kind of interest there is in this package of legislation.

That is of course because this is, after all, public interest legislation. It is legislation that gives the public a louder and clearer voice than they have ever had in how the health care system operates. Public members will make up a larger proportion of the councils, sharing those duties with professional members. Their numbers will rise so that they comprise almost one half of the council, up from a quarter or less that existed in the past.

1020

The public will also have greater representation on discipline committee panels. The Health Professions Regulatory Advisory Council will be made up of people who are not health professionals. Its role will be to offer the minister advice on proposals from the public, on changes to law governing health professions, on which other professions should be regulated and on quality assurance programs.

This is also legislation that offers the public more protection. In talking about public interest and public protection it is one of the reasons that we hope you as a committee will be able to hear from health care consumers and hear the public's reaction to this. That is a daunting task, because as a group they are not as well organized as many other voices within our society. We hope there will be an opportunity for you to hear from health care consumers and that you will take their concerns and their opinions into account in your deliberations.

As a piece of legislation designed to protect, within the legislation you will see that there is protection in the form of the 13 categories of controlled acts contained in the umbrella act. Only certain health care providers will be

able to perform these potentially hazardous acts and any others performing the controlled acts could be fined. There is protection in the form of quality assurance programs that the various colleges will be asked to develop and undertake. Each college is to have these in place three years after the legislation is passed.

I think you will hear, as I did in meeting recently with representatives from InterHealth, that there are some concerns with respect to the development of quality assurance programs. It is not that there is any disagreement that it is an excellent idea and that it is an appropriate role for the colleges, but there is some concern that there be some consistency across colleges in terms of how these are developed and that there be some assistance from the ministry with respect to this. It is a message that I heard from InterHealth and will be taking a look at.

Each of the colleges will design its quality assurance program to ensure that its members maintain their skills and continue to learn what they need to know to provide safe care. Equally important with that, the program will address the provisions of effective and appropriate care. I think we have seen, as quality assurance becomes a major focus within the health care sector, the importance of that aspect of quality assurance programs.

The RHPA will help create an environment of better understanding and trust between health care professionals and the public. There will be trusts built not only as a result of health professions showing their desire to ensure quality care with things like the quality assurance programs that I just made mention of, but as a result as well of the professions' willingness to enter into a new and more open partnership with the public. The new partnership I am referring to will be nurtured due to increased participation of the public on college councils, and trust will also come as consumers feel more confident in the complaints process, which will become more open and accessible.

Consumers will be assured when they are made aware that they have the right to complain. They will feel a greater sense of confidence as they see their rights honoured. This will come as they begin to see their complaints more often translated into investigations and as they see investigations resulting in action.

This legislation also brings women closer to achieving equality in the health care system, in a system that has been dominated by men. All of the seven new professions that are being regulated are predominantly female health care professions. They are audiologists, dietitians, medical laboratory technologists, midwives, occupational therapists, respiratory therapists and speech language pathologists. As well, dental hygienists are getting their own college.

One of the dramatic changes represented by this legislation is the choice women will have in how they want childbirth conducted. This legislation rights a wrong that was committed in Ontario over 100 years ago. It was back in 1865, to be exact, that the Ontario Legislature reversed a policy concerning childbirth, taking away the exemption that midwives had in the Medicine Act. Until 1865, midwives were able to practise midwifery without a licence to practise medicine. The inclusion of midwives in this legislation represents the effort of hundreds of individual

women and a smaller number of practising midwives who, through public education and lobbying and education of other health professionals, demonstrated the need for and the consumer demand for midwives.

The RHPA rectifies the lack of input that women—in fact the entire public—have had in the system governing health care. We are hopeful this legislation will also help to simplify the process of making changes to our health care system. It is my hope that, with RHPA, future policy-making will be more flexible and more responsive to public concern.

As I indicated, I am submitting to the committee today a number of draft amendments to the RHPA and the procedural code and the health professions acts. The changes I am proposing incorporate suggestions of the professions and their counsel. I am confident that we at the ministry, along with the legislative counsel who have responsibility for the language of the bills, have been able to find better language for many of the clauses of the legislation where there had been a lack of clarity. In some of those situations we are talking about minor housekeeping amendments to language. For example, there is an amendment that would make it clearer than it was under the previous wording that any controlled act may be delegated. This is coupled with a regulation that would authorize every college to make regulations governing the delegation and restricting which acts may be delegated and under what circumstances.

We have also been able to rectify several omissions where wording in sections was not fully thought out. For example, there is also an amendment that would permit a discipline panel to exclude the public from part or all of a disciplinary hearing. However, a complainant and his or her representative could remain present at the discretion of the panel. I do not believe that these amendments will be perceived to be contentious.

Proposals involving the increased public membership on councils to just under half that would set the exact numbers of professional and public members are being discussed with some of the professions, and those are not available in the package I will be submitting to you today. They will be ready before the clause-by-clause process, however, and again in those situations we are working closely with the professional groups in trying to arrive at a consensus and agreement about that structure before we table those amendments. I hope when you see those they will be ones that will reflect the spirit of the government's desire to have increased public participation but will also come with the support of those professional bodies and will not be a contentious issue for the committee.

There are a number of amendments to the scopes of practice and authorized acts in several of the health professions acts. Those being released today concern what I believe will be perceived as non-contentious matters. For example, one of the amendments is to the Medical Laboratory Technology Act. It would authorize technologists to draw blood for testing. That is pretty straightforward. It was missed in the scope of practice and is something that the profession has made us aware of, and we are proposing in the draft set that it be rectified. Another would authorize midwives to draw blood from newborns, to catheterize women and to prescribe from a limited list of medications.

There are amendments we are considering that I think will be very helpful to hear the committee's concerns and thoughts and recommendations on from your review of the legislation. For example, unregulated practitioners still have concerns about a diagnosis controlled act, as do some of the regulated professions, to which this act has not been authorized. This is a very challenging issue. The Chair smiles, and I know that she has struggled with this for some period of time in her time in the portfolio as Minister of Health, and the ministry continues to struggle with it, as do members of the various professions and the unregulated practitioners, trying to find a solution to that language that will meet people's concerns. Clearly I am looking to you, to this committee, for help with the task of coming up with a diagnosis controlled act that, bottom line, provides adequate public protection without making it impossible for practitioners to communicate as fully as is desirable with patients.

I know there are also concerns about the wording of the provisions restricting the use of titles to regulated professionals. I have heard from some of the professional groups about this, and I expect you will. It is an area that we are looking at how we could amend to satisfy those needs, where again, meeting the challenge of a bottom line, which is to help the public get sufficient and accurate information about the practitioners, both regulated and unregulated, whom they seek to see.

1030

In closing, I would like to tell the committee that I consider the RHPA to be living legislation, both in terms of the work you have ahead of you and, once passed and proclaimed, what we will continue to see through the process of the health professions advisory council reviewing the act or parts of it continuously. It is also our intention to have a full review of the legislation in five years' time.

For my part, I will be open to submissions made here at the standing committee, and I am also anxious to receive any recommendations the committee will offer. This legislation has been through eight years of development with a lot of time and effort on the part of members of all three parties and many ministers of Health, and I think that we are all in a truly non-partisan sense committed to seeing the best piece of legislation developed here for the protection of the public. I am very open to the kinds of suggestions that I know the committee will come forward with to try to improve the legislation. The bottom line is to try to balance all of the concerns you will hear with the main thrust of the legislation, which is to provide that kind of protection to the public that all of us believe is important.

Last, I just want to inform the committee, with apologies, that I will not be able to attend all of the hearings you will be holding to hear the submissions at first hand, and it is with much regret, but as I hope many of you will understand, being in this new portfolio for only three months I am still filling many of my days with briefing sessions, getting up to speed on the ministry in many other program areas. I hope to try to balance that ongoing schedule with some attendance here during your hearings as well.

I also hope that in a timely fashion I may have a parliamentary assistant appointed who will be of assistance to me in this as well. In the meantime, there will be members

of the ministry staff and of my own personal staff who will be attending every day in order to keep me briefed and informed of what is going on. I wish you well in your deliberations, and I thank you for your time this morning.

As I indicated, Linda Bohnen and Alan Burrows are here from the ministry and will be able to spend much of the time today with you answering your specific questions and leading you through a background explanation of the history of this and where we have arrived at with respect to some of the sections and why we have arrived at that place in the controversial discussions that have gone on.

The Chair: Thank you very much for the opening statement. Are there any questions of the minister at this point?

Mr Beer: I think we are all a little overwhelmed at the paper that is flowing around all of the different acts. But I wonder if we might take advantage of your presence this morning to look at some of the principles that we should be guided by as we look at this legislation, because it seems to me that it becomes critical. You mentioned earlier the whole notion of balance, and I think certainly in all of the work Mr Schwartz has done and in the discussions we as individuals have had with the different groups, both in the last month or so and over the last number of years, we recognize that we are trying to do a number of things here.

I would like to focus a little bit on principles and then ask you for some of your thoughts on a couple of specific points. You mentioned the question of the public interest and also the question of public protection. What kind of conflicts do you see that are inherent there as we look at this legislation, and is it the view of the government that when in doubt we should always try to go in terms of the greater public interest? How do we view that balance, because clearly a number of the regulated professions will express and indeed have expressed concerns from the perspective, as they see it, of public protection. But if you were looking at the principles, what are the ones you think we should be focusing on in terms of how we look at this?

Hon Ms Lankin: I think there are a number of parts to the answer that I would like to touch on.

First of all, with respect to the fact that we are dealing with health professions which are self-regulating, that is an important part of the balance to remember. At the same time, we want to ensure that the public interest is held high, both with respect to the purpose of the legislation and also with respect to the ongoing self-regulation of those professions.

Therefore, because of the enhanced role the public will play in the councils of the colleges, I think the education of the public members is a very important piece of this and one in which you may hear some concerns from the health professions themselves.

Concerns have been raised about what it means to be self-regulating and about the balance needed between outside consumer public participation on those councils and the number of members from the professions themselves. Those concerns are where the issue of the public interests and the balance come to the forefront. We are proposing an increase, as you know, in the number of members of the public that participate there.

I think that is important. I think some of the colleges will have some very difficult issues to deal with. For example, the College of Physicians and Surgeons will have to deal with the task force on sexual abuse and some of the recommendations that come forward there. There needs to be that kind of a balanced discussion that takes place within the college itself. I think the role of the public in those kinds of discussions on the council will be very valuable.

The other thing I would say is that much of what I expect you will hear with respect to issues around scope of practice—and I think you will hear a lot about that—and around some of the controlled acts has a lot to do with the relationship between professions. It is important for you to look at that from a point of view of whether it truly has a major impact on the public interest and on protection of the public.

I think that in the discussions for years during the review, many of us individually have met with all sorts of representatives of groups who can effectively make the case for some nuance, some change in the scope of practice as it has been proposed through the review and now through the legislation.

My thoughts or my experience I guess to date has been that when you start to look at the changes in some areas, sometimes there is a counter point of view that you will hear from other professional groups that it would affect. Many times, the consumer is not front and centre in that discussion. I think the committee needs to look at that.

There is a process for ongoing review through the advisory council and for a process for ongoing changes to the regulations and to the legislation.

I truly believe that after so many years of having a review of these issues and of legislative development, we need a period of time of experience with the legislation in order to be able to judge whether the review itself got all the individual scopes of practices exactly right.

Again, I think there is a question of balance in there, and if you are to look at moving parts and pieces of scopes of practice it would be, I would argue, most important if that were done with the public interest in mind as the reason and rationale as opposed to some of the competing interests between professional groups until we have had a chance to see it in practice and play out.

Mr Beer: Just one thing, because it comes up in a lot of the material as well: When you refer to council and college—because I want to be clear—by council you are always referring to the advisory council—

Hon Ms Lankin: No.

Mr Beer: I see heads nodding, so can you just clarify? When you are talking about council, that can mean either the advisory council or what we have called in the past—

Hon Ms Lankin: I will ask Linda Bohnen to help me out with the technicalities of this, but the advisory council in and of itself is a separate body and within the colleges when we talk about appointments to the council of colleges, it is like the executive ruling group of a college.

Ms Bohnen: That is correct. The council is like the board of directors of a college. We try to remember to say advisory council when we mean the advisory council.

Mr Beer: That comes up in a number of places and I know when we get into some more of the detail we want to be clear to what body you are referring.

If I could go on from that, it seems as though if we try to identify the overarching issues—and you have referred in some ways to them in your introductory remarks—the question of diagnosis and assessment, and how we work through that, the question of the harm clause, the other question that has come up is that of ministers' powers.

1040

You or the government—it was the minister just prior to you—said there was not a need for a harm clause. I guess a year ago the previous government had said, "We will have the committee look at drafting a harm clause." Could you share with us your views for in the end recommending that there simply was no need for one, because again that is one that has come up from a number of groups? I am sure they are going to be asking us, in some cases, to continue to leave it out or to put something in. What was your reading in terms of finally saying there should not be one?

Hon Ms Lankin: As you are aware, when we tabled the legislation for first reading, the previous Minister of Health announced that we were in fact going to be dropping the concept of the harm clause or the basket clause. In all the deliberations around the balance between that and the controlled acts, and diagnosis as a controlled act in particular, it appeared to us that the actual 13 controlled acts are where the public would receive its protection from hazardous acts on behalf of professionals and on behalf of unregulated individuals being prohibited from performing those 13 controlled acts. It seemed to us as we looked at it that the addition of the harm clause or the basket clause—no matter which way you attempted to word it—really was ancillary to those 13 controlled acts and that they provided the basic protection.

When we go through the presentation this morning, ministry staff can give you a bit more detail in terms of some of the wording that was looked at and why in discussions with many of the groups out there it was felt that the controlled acts sufficiently dealt with that issue.

Mr Beer: As we go through this morning, are we going then to be dealing specifically with some of these? If so, I can hold back on my questions.

Hon Ms Lankin: Some of them certainly will be addressed, I think as I did in the presentation. The issue of diagnosis, certainly the issue of title protection, those sorts of things that are controversial, we know you will be hearing submissions on. We want to provide you with information to be able to assess those, as opposed to diagnose those presentations and make judgements on the information.

Mr Beer: You are going to be providing further information. I just do not want to take up the committee's time if we are in fact going to be going into each of these in a more specific way. I know other members may have questions of a broader nature of the minister. If that is the case, I can hold and we can talk more specifically about the harm clause diagnosis and ministers' powers.

Hon Ms Linkin: In the presentation, we have not actually planned on touching on the issue of ministers' powers, but we can do now. I will ask Linda to do that.

Mr Beer: What I was particularly interested in there again is just the rationale in terms of the change and what problems you anticipate or what questions have been raised around the ministers' powers if this act were to go forward as it is.

Hon Ms Linkin: We will make sure that we do that.

Mr Callahan: I just want to inquire, as a result of these acts, will any of the specific groups be retired or put out to pasture? I notice that in Bill 45, it says in subsection 3(2) "No person shall be added to the class of members called podiatrists after the 31st day of July, 1993." Is that a limitation or is it simply saying that from that point on you will be chiropodists?

Ms Bohnen: From that point on no one would be registered and authorized to perform the additional controlled act and scope of practice of podiatry. But certainly from that point on individuals may be registered as chiropodists.

Mr Callahan: What you are doing in effect is creating a specialized group that never again will be given that authority of podiatrist by shutting it off on July 31, 1993.

Hon Ms Linkin: It is a grandfathering of a group of individuals in the system who had historically both felt empowered and able to perform certain duties, in some cases through the training and also through the nature of practice. The review itself, as it went through and looked at the balancing of this and the training that was required to perform those duties, felt that chiropody was the appropriate place for that scope of practice to rest. I think the review and the development of the legislation under the previous minister really attempted to ensure that people who were in the system and had the skill and background of years of practice in performing these duties were protected by being grandfathered. That was the intent there.

Mr Callahan: So do I understand it correctly that podiatrists perform a much broader scheme of practice than chiropodists do or will do under this legislation?

Ms Bohnen: Typically, what a podiatrist does that a chiropodist does not do is surgery on the bone of the toe and the forefoot, the front part of the foot. Chiropodists do not do that. The decision to essentially grandfather but cap podiatrists who do perform this additional surgical function was negotiated by the review. It was consistent, I believe, with Ministry of Health policy during the late 1970s and 1980s that foot care in Ontario should be provided by chiropodists who do not do surgery on the bones of the feet.

Mr Callahan: I do not want to press this, but does that mean that the people who become chiropodists after this will not have the authority or the training to perform what podiatrists did pre-1993?

Ms Bohnen: Chiropodists do not now perform bone surgery; podiatrists do it. Chiropodists do not do it today.

Mr Callahan: So what happens if you are capping them or grandfathering them? You are in fact creating an exclusive class and you will have no more podiatrists, right? If that is the case then it is kind of like shutting off

the licence plates for a taxi company. You make them very much more valuable. It is almost a revisiting of the QC issue, if you want, but does that not establish a special class or profession that perhaps is not desirable? It is going to force that type of work to be done by medical practitioners, which is going to be far more expensive for the health plan of this province?

Hon Ms Linkin: I think you will find through the course of the review that many difficult issues like this were taken on, a balancing of these sorts of competing interests that will come forward. That is something that, as we go through the presentation and as the committee hears from groups, I will ask you to look at: Did the review and did all of the processes that led up to that get these answers right?

A lot of time and energy has been spent trying to answer some of these very difficult questions around scope of practice and around opening up. In fact, we believe the regulation of some of these further groups opens up the provision of health care services to a broader range of professional groups as opposed to limiting it. The committee will have to look at whether in the case you actually raised that is the case or not.

Mr Callahan: I am only subbing on this committee and I have not had a chance to look at the other acts, but do any of the other acts that are before us grandfather a previous profession and its scope? On the other side of the coin, I think you have already told us there are acts that enlarge the scope of various groups regulated by this legislation. If that is the case, I would like to know. I am not sure about the other members of the committee, but I would like to know, as we receive our briefing from the ministry, if they could list those that limit or grandfather and those that expand so we can take specific note of that in terms of addressing the issue.

1050

Hon Ms Linkin: Yes, that is part of the briefing that is scheduled for today, this afternoon in particular.

Just to go back to the previous issue, I wanted to make note that the chair of the board of podiatrists and chiropodists apparently can speak very well to this particular issue. Her name is?

Ms Bohnen: Dr Diana Schatz.

Hon Ms Linkin: If she is not scheduled to come before the committee, she may be someone the committee may wish to hear from if that issue becomes one you wish to pursue.

Mr J. Wilson: Thank you for your opening statement. I know we are going to get into a lot of specifics during the briefing, and I could continue on Mr Beer's first line of questioning on the diagnosis clause. I will do that for a minute. I was going to skip that, but I will do it. I did not quite understand and I am trying to get a feel for it, because I had a lot of groups, as all members have, that have met with us in the past months and weeks. It has been suggested by a number of groups that perhaps the clause should have been scrapped altogether. Not being an expert in this field at all, can you once again try and give us a feel for the direction you are going with that?

Hon Ms Lankin: I will very briefly, and that will be part of the detailed briefing you will receive today. In my comments I addressed what I as a legislator, the same as all of you as legislators, have heard from members of various groups out there. Most particularly the unregulated practitioners have brought forward this concern, but not exclusively the unregulated practitioners.

There is certainly a concern that whether diagnosis is a controlled act, by virtue of the definition of diagnosis, it will limit groups that are not regulated and authorized to perform this controlled act of diagnosis from doing what many of us would agree is very good and important work. That would be people like clergy, social workers and other groups that work with people in a human situation of looking at what problems people face and making an assessment of those problems, communicating to people about that assessment and helping them determine a course of action they may follow.

The line between what is an assessment and what is a diagnosis and what is communicating assessment and communicating diagnosis has become very controversial and is one where we have not at this point in time been able to develop language that meets everybody's concerns. On the counter side of that, if you were to eliminate it altogether, you will find members of those regulated professions who are authorized to perform that controlled act feeling that there would be great danger to the public and to public safety.

It is very controversial and difficult and we truly do look for assistance from the committee. You will hear more detail on that in the detailed briefing.

Mr J. Wilson: We were sent amendments on July 31. In those, I did not see any major changes to that clause. Do you have further amendments today on that?

Hon Ms Lankin: No, what I will be tabling with you today is what I sent out for information in advance, the draft proposed amendments that reflect our thinking, and as I indicated in my opening remarks, that does not include amendments on some of the most controversial, like diagnosis and title protection. We do look to the committee for assistance after you have heard from members of various professional groups, but also members of the public, because by and large they have been unheard thus far in the legislative development process.

Mr J. Wilson: Thank you, that is helpful. I guess my final question or comment is that it seemed to me that in deliberations over this legislation with groups there was an awful lot of confusion. I know this legislation and the development of this legislation goes back what, nine, 10 years or more? I was wondering if at some point you will have, or perhaps you have already, a communications plan. When the committee's deliberations are done and this is enacted as the law, I do not think it is sufficient in this case to just gazette the thing.

I was wondering if the ministry has given any thought on how we are going to get the message out to people exactly what the rules are, because during the development of this there certainly was an enormous amount of confusion, and as amendments came forward they were not, I did not

feel, very well communicated in public. That is a problem, I understand, not just for the government, but mainly in this case because it is such complicated legislation and deals with so many acts. Do you have any thoughts on that? It has probably been an area of frustration for you.

Hon Ms Lankin: Preliminary thoughts at this point in time—and again, if you have thoughts you would like to put forward, I am sure that would be helpful to us. For example, the ministry has been working on how groups that have no professional college get to the point of having a professional college, the kind of education program we will need to develop and assist with in regard to members of councils of colleges. That will include dealing with the role of being on a council of a college for those professionals as well as for members of the public. An ongoing public education for public members I think is really important.

Additionally, I have just been advised that there is work going on in terms of developing a consumer brochure that will explain in some ways. There should have been copies of that available for you today that will help show you what that would look like.

There will be much more than that planned and pulled together, but at this point—a lot of that work has gone on in the ministry. You will appreciate that this legislation was anticipated to be passed under the previous government, so there is much work that has been done. We will certainly make use of that and any other recommendations you may have.

Mr Hope: I just have a couple of concerns. Thanks, first, Madam Minister, for coming this morning. You talked about amendments. The amendments are only ideas you have and you are looking for public input, through what we hear, comparing the amendments you are looking at plus what we hear in drawing up some type of long-term legislation. So what you are really doing is just giving us a sight of some of the concerns that you have been hearing from the general public and from those professionals to try to straighten up the legislation. Is that what you are trying to get across?

Hon Ms Lankin: Yes. I will be circulating officially those draft proposed amendments today. I will also circulate copies of my opening remarks to you. Most of you have seen the draft amendments, and they are very detailed and technical, and I want to give some reference from my remarks about what is there and what is not there.

I think it is important to keep in mind, with what we are tabling as draft amendments, three things: Some of those are what you could describe as housekeeping amendments, ie, clarification of wording and/or correction of wording that occurred in the legislative drafting before; some of them deal with issues around scope of practice where there were clear oversights and they are non-contentious in terms of bringing those forward, and some of them are procedural. None of them in any way deal with the very meaty contentious issues this committee will have to deal with in regard to the kinds of things like diagnoses and title protection that we have been talking about here.

The reason for circulating them in advance is that, for some groups, those, although not controversial, were very important aspects of change that they felt it necessary to see.

We wanted to give people clear indication that on those they had been heard and to let people have an indication of where we were headed. We thought that was important both for the committee and for the groups coming forward, the presenters, so as not to waste a lot of time if that resolved problems.

But overall I guess what I want to stress is that I truly do want to hear from the people who will be coming forward and making presentations and from the committee's deliberations of those presentations. We are open to further amendments.

Mr Hope: There are a couple of other comments I would like to make. I have had the distinct pleasure of meeting a lot of people all over this province, especially from rural Ontario, where I come from. They are looking at this legislation as being detrimental to the hospital costs. It will increase the costs of the hospitals. Especially with the nurses, one of their emphases is that rural Ontario hospitals may be experiencing more cost, as they see this legislation.

The other thing they were concerned about was the transition period for this legislation into reality. They were concerned about the transition part of it. Is there a mechanism in place for the transition, and has the legislation given sight to those of rural Ontario that there is a certain need? We do not live in large urban centres like Toronto, Windsor or London. We live in smaller, rural settings in which we do not have the expertise. We have a hard enough time getting doctors to come to our area to live because of a different standard of living.

These are some of the concerns they keep bringing across to me and I just want to air those concerns. I do not need an answer to them, but I think it is important that you hear some of the concerns they are telling me from rural Ontario: the additional costs of the hospital, getting doctors and providing less service in rural Ontario, which means we will have to travel more again to get services in either London or Windsor. I think they are important issues. We have to listen. Is the legislation going to really hurt rural Ontario as we see it coming through?

1100

Hon Ms Lankin: I will certainly be interested to hear through the public hearings if that kind of submission comes forward and if the committee hears that there is a concern that needs to be addressed there. I would think that there is in fact an alternative way of looking at it, which is to say that as more health professions are regulated and brought on stream with a self-governing structure and a clear scope of practice in which people can access health care from different groups of providers as opposed to only the medical profession itself, it opens up the health care system and it makes it more accessible for all Ontarians, rural and urban Ontarians. Let me say I do hope that if that is an issue and a concern, the committee will hear that and your recommendations will reflect that.

With respect to the transitional issue, I spoke to that. We are certainly aware of the need to have transitional plans. Again, in the meeting with InterHealth last week this issue was raised. Groups will need help with respect to setting up colleges and getting those colleges going and we

are looking at the establishment of some transitional teams working with those professions so that we can make it as smooth as possible. Before we have confirmation, we want to make sure there is a system in place in order for people to access a system that is working and viable at that date.

Mrs Cunningham: Madam Minister, thank you for your presentation this morning. I was quickly enlightened to hear you say that draft amendments—and you emphasized the word “draft”—are just that. That, for me, will be a very special experience, because I have sat on this committee before, more recently through Bill 17, where there were very strong recommendations from the public and, in my view, we did not make the changes that were necessary. I think we will live to regret it.

I think you are very sincere in saying that you are looking for some solutions to this problem around the diagnosis issue, and I commend you for saying you are listening, because I think it is a very serious problem for us. I think all of us would not be here if we did not support the system that was so important to our health care in this province, and that is a system of laymen and volunteers who provide a tremendous support. We do not want them, to be subject to litigation and fines in their work, and I think it is our responsibility to find a way around that.

It is almost like “Smoking is dangerous to your health”—you know, the sign you put up in front of your door—and people come in and do it anyway. If people clearly understand that a child care worker is there to make recommendations, to make referrals—general practitioners do the same thing, and we have to find a way to protect people who are there to help others. I do not think we have done it so far. I just wanted to put that on the record and commend you for your sincerity in listening.

The question I have of you is a time-frame question. There seem to be an awful lot of individuals. I am curious to see what they are going to tell us. There are more individuals than professional groups and specialties coming before the committee. I am wondering, from your point of view, how you will treat their special presentations, because my instinct is that you are going to hear a lot of things about health care from them and from their own experiences. Would you have any advice for the committee as to what we should be doing with that if it is either directly or maybe not directly related to this legislation? I am wondering what you plan to do with that.

Hon Ms Lankin: That is a very good question. I think there probably will be a lot of instructive information that will come forward. I have not actually thought about that, and I think what I will do is take your question away with me under advisement in terms of how we could best make use of a lot of this information. Truly, I believe that I and other new legislators who form this committee may hear things that we are hearing for the first time. For others, it may be a chance to hear it with a different focus of intensity, coming from individuals and health care consumers. There should be good use made of that. I agree with that sentiment and I will have to think through what that means and how we can do that.

Mrs Cunningham: Just from my point of view, in my office in London I have heard a lot about title protection and certainly the powers of the minister. So I am expecting we will get a little bit of that. It has also been difficult for me to sort of plan that day in London. I do not know if the clerk has had very many calls, but we have had a tremendous response in our own office. I have already looked at the list and know that four or five of the ones I would want you to hear from are not there. Either they have not called, or it is full or something. I certainly know I have had a tremendous response.

There is a hope, I think, that when people come before this committee and take the time to make a presentation, somebody is really going to listen to them. I was not particularly pleased with the last bill—even with this government, I must say. I do hope we are going to be looking for solutions. I might warn you that it might take a little more time than we have given it.

There has been so much leading up to it. The former minister knows about that. She herself, I think, hoped that we would have come to some conclusions before now. All of us are in it together to make some legislation that is going to be long-lasting, but I it may take a bit longer. I wanted to make that public, given the kinds of things I have heard from patients and health care consumers in London.

Hon Ms Lankin: I am heartened to hear that there is that kind of expected participation from patients and health care consumers. It is one of the things we had hoped would happen during this process, because we feel there has not been a vehicle before these public hearings to have easy input from those groups. As I indicated, of course, they are not always the most well organized group, and it is hard to have ongoing, effective representation. So I am heartened to hear that.

With respect to being open to amendments: There is absolutely no unwillingness to try and deal with some of the very real issues. However, as I indicated to you before, when you start to look at making moves in certain areas, the balance throughout the whole package of legislation that was arrived at—as you are all well aware from the very long process of the legislative review—starts to create problems in other areas that you need to address.

So I ask the committee, when you look at proposing amendments, to ensure in your own minds that they do not create an effect that will leave us in a problematic situation, trying to deal with issues that compete with each other and trying to strike a balance, even though you are under the guidance of the Chair, who is probably the most experienced in this area.

The Chair: Just for clarification for the committee, Mrs Cunningham raised the issue of representations and time slots. The committee dealt with the amount of time available for meetings. For your information, the clerk has had an overwhelming response. The time slots are pretty much full. In London, in order to accommodate as many people as possible, the hearing hours have been set earlier in the morning and extended through the lunch-hour.

The committee, as I said, discussed this, and the sub-committee spent quite a bit of time on it. The view was

that any groups that could not be heard would be placed on a waiting list, and that if there was time or cancellation, they would be slotted in. They would also be encouraged at any point through the process to submit their concerns in writing if there was insufficient time to hear everyone.

The other thing the committee should note is that there have been several requests for changes in time slots. The clerk has undertaken, wherever possible, to accommodate them, but it is proving difficult because it would mean changing with somebody else and moving that around.

I just wanted to make that point to the member who raised the issue of participation at these hearings. I would commend the clerk for the work that she has done to date in attempting to accommodate as many people as possible.

Hon Ms Lankin: Madam Chair, if I may, I will leave at this point.

The Chair: There is one further question. Mr Owens, and I believe Mr Beer, had one last question for the minister. We will try to have you out of here as quickly as possible.

Hon Ms Lankin: Okay.

Mr Owens: It is more of a quick comment and perhaps a bit redundant, but the remarks that Mr Hope raised with respect to the rural areas are, I think, quite valid. My experience in the health care area is that what happens in Toronto after 5 o'clock is not necessarily what happens in Sault Ste Marie or some of the other smaller communities that we may hear from.

I have a concern that the legislation may be a bit Toronto-centric in its focus. I certainly hope you will entertain amendments to widen areas around the scopes of practice and the diagnosis clause that will help widen the ability of practitioners in smaller communities to continue, as they have been doing until now.

Mr Beer: Before the minister goes, I just want to be clear on one point. You have said you are interested in the recommendations we may come up with, and I respect what you have said. But I think it is important for us to be clear on the government's intentions. I do not want to put words in your mouth, but let me phrase it this way.

It is still the government's policy that, unless there is some argument which you have not yet heard, there should not be a harm clause; and it is still the government's policy, unless you hear arguments to convince you otherwise, that the way in which the diagnosis clause is expressed in the legislation represents the closest balance that, in the government's view, you can find.

I say that because I think there is a difference here between saying, "Look, this is what we believe is the appropriate way to go," and you yourself saying to us, "Look, as a minister who came in later, I have some personal concerns about the harm clause and I would like to hear what you have to say." I just want to be clear, as we go about our work, on the government's policy. Have I expressed it correctly?

Hon Ms Lankin: That is a fair question. I would say you have expressed it in part correctly. Let me try to build on that so that the committee does have a clear understanding of where we are coming from at this point.

With respect to the harm clause itself, at this time we believe that the 13 controlled acts do cover the necessary elements of public protection that we want to achieve with the legislation. We do know, however, that it is an area of interest and concern to a number of people and we will expect that you will hear representation.

To this date I have not heard representations that have convinced me that we require a harm or a basket clause to be reinserted in the legislation. You may, and I am open to hearing that, but at this point it is not our intention to reinclude a harm clause.

With respect to diagnosis as a controlled act, I think we are struggling to find the appropriate amendment to balance the concerns of those professions that believe strongly in the need for diagnosis as a controlled act and those groups that feel it will inhibit their ability to perform good human service work. I think there is a need either for greater understanding and clarity of what is there or for an amendment which can provide that sense of comfort to both groups.

We have not yet been able to come up with an amendment that meets those concerns on both sides. We have worked with various groups in terms of possible wording. There have been a lot of amendments proposed and there have been some problems and nuances of problems with all of them. But we are still looking at that. I think it is an area in which, if we can receive some assistance, we would be open to amendments.

Mr Beer: Briefly and finally, the decision to take out the harm clause, was that a ministerial decision or one taken by cabinet?

Hon Ms Lankin: I think that is not an appropriate question, but I do not have enough experience to know whether I am on the borderline. Any legislation put forward is the government's legislation. That is the approach I would take.

The Chair: Minister, will you be available later today to answer further questions following the ministry's briefing?

Hon Ms Lankin: I can attempt to be available, if that is necessary. I can be reached through my office and I can attempt to reschedule other events.

The committee recessed at 1116.

1130

The Chair: We have a presentation from the ministry. Ms Bohnen and Mr Burrows, proceed please.

Mr Burrows: It is our pleasure to be here today to make a presentation on behalf of the Ministry of Health. On a personal note, I would like to say that as a bureaucrat who has been involved in this process for three years now and as a health professional myself, it is a double pleasure.

I should explain just briefly what our branch does. The professional relations branch is essentially responsible for liaison with the health professions. Its primary task right now is providing bureaucratic support to this legislative process. Working with us is Linda Bohnen, who is counsel. We have the distinct pleasure of having in Linda not only an excellent legal mind but a repository of knowledge about the review, since Linda also served with the Health

Professions Legislation Review before coming to work on contract with the ministry on this project.

What we would like to do today is to take you on somewhat of a history lesson. I would like to talk about the Health Professions Legislation Review. Since six years were spent on this, we felt it worth spending some time, because many of the issues that will come to the committee are issues that really have been in discussion between the review team, the ministry, consumer and provider groups for many years.

After that, Linda is going to talk about the outline of the regulatory model that is contained in the legislation. She will also touch upon how a balance has been struck with respect to each profession's particular interests. Then we would like to talk about specific issues, such as the diagnosis and harm clause. At the end of that time there will be plenty of time, we hope, for questions and answers. In the little break we just had there were obviously a few hot topics on people's minds, so we will be prepared to answer any questions you might have as best we can.

You should each have a copy of a binder. The title page under tab A reads, Briefing—Standing Committee on Social Development. We will be going through this in relatively the same order it is presented, so if you want to follow along, I will try and remember as we go along to name each tab that is the relevant document to what we are speaking about.

Before beginning, however, I think it is worth spending just a minute or two on the context, because the context under which the Health Professions Legislation Review took place, from 1982 until the end of 1988, really has not changed. We currently have a system which has a fragmented regulatory framework for the regulation of self-governing health professionals. The legislation is largely outmoded; it dates back to 1925. There are no quality assurance programs inherent, with one minor exception, in the existing legislation. There is a lack of protection for individual patients and individual registrants of the various professions and structurally there are problems. For example, one of the reasons the Health Disciplines Act has not been amended is because it was a very difficult thing to do with all of the profession-specific material in the body of one statute. It meant that to open up that statute, legislators would have been faced with the problem of trying to resolve competing interests at the time. That structure, of course, remains today.

Also, there was a need to incorporate new professions. Things change. There are new technologies, some of which are potentially harmful. Professions were bringing forward their own suggestions for regulation. There was a lack of a meaningful process to deal with all of these issues.

We have heard about the powers of the Minister of Health. There is a public expectation of government that when something goes wrong, when a patient is abused or misused, somehow the government can in some way influence that, particularly where there is a general trend affecting society. The bottom line is the need to protect the public from harm.

That context, which existed at the time of establishing the review, really still exists, because the legislation has not been updated or changed or given a new framework or

new public involvement. That leads us to why we are all here today.

With that kind of contextual statement, I will turn to tab B, which is the mandate of the Health Professions Legislation Review.

In November 1982, the then Minister of Health, Larry Grossman, announced the creation of the Health Professions Legislation Review with a particular mandate to make recommendations to the Minister of Health with respect to which health professions should be regulated, to update and reform the Health Disciplines Act, to devise a new structure for all legislation governing the health professions and to settle outstanding issues involving several professions. Colloquially, those things are called turf disputes.

I mentioned the various pressures that were on for change. They are listed in this. I will not repeat them. Suffice it to say that those pressures still exist today.

Turning to tab C, this highlights the stages of the consultative process undertaken by the review team. The review team was headed by Alan Schwartz, a Toronto lawyer. It consisted of Mr Schwartz, a very small support team and a consulting firm. The technique that was used was a series of questions, going out and working with the groups involved, those professions and consumer interest groups who were involved in a review.

You will see the first page in tab C lists 20 communications from the review. I will not go through them individually, but they started with inviting participants, working through such things as who should and should not be regulated and, towards the end, dealing with actual legal and procedural proposals and the scope of practice and title protection issues, those things of specific interest to individual professions.

If you look at the next section under this tab, it lists the participants and others in contact with the review. Some 300 groups and individuals were involved in the review process over its six years. They range from unregulated to regulated groups and those which sought regulation, consumer groups and many individuals.

As I pointed out, the review team went out with a series of communications to the interest groups, asking questions, asking for responses, and then refined those responses over a period of time, asking more and more specific questions to the point where basically the questions had been answered and recommendations could be made to the government.

That brings us to tab D, which are decision points during the process. In this section we have government announcements. I will hit the highlights on those to refresh everyone's memory, and then we would like to spend significant time on the criteria for self-regulation, the professions to be regulated, the criteria for controlled acts and a little bit about title protection. Then Linda will take over.

If we look at the specific announcements, I would like to point out one thing. While the review was going on, it was totally at arm's length from the government and there was no parallel process in the Ministry of Health. There was one person who, if the review team had bills that needed to be paid, made sure that took place. Also from time to time, when the review was ready to finish one phase of its endeavours, and go forward, it needed some policy direction. The individual in the ministry at that

time—Paul Gardner was his name and he deserves, I think, a lot of credit for the six years of work he put in in support of the review team—brought those things forward and sought the necessary direction and then was able to convey that back to the review team, which allowed it to get on to the next phase of work.

1140

If you look at the government announcements, they start with one in November 1982. It mentions Mr Grossman. It simply says that each profession would be asked to participate in the development of legislation for its own profession under the aegis of an independent review.

Flipping the page, we see that the next announcement came in August 1983. This was made by Keith Norton, the minister of the day, and it announced that the review team would be headed by Alan Schwartz and he would be supported by the Canada Consulting Group in the endeavour.

Flipping the page again, we find another announcement. This is dated January 1986. This was made by the Minister of Health, Murray Elston, and announces the midwifery task force being created. The task force was struck to establish and to recommend to Mr Elston and to the Minister of Colleges and Universities a framework for how midwifery should be practised in Ontario and how an educational program could be developed and implemented. It was chaired by Toronto lawyer Mary Eberts and was asked to address the issues of training for midwives, professional requirements, scope and standards of practice, governance of the profession, location of practice, patient access, hospital status and whether midwives should operate as independent practitioners or as part of an organized service. The task force was undertaking its initiative at the time the review itself was going on.

Then in April 1986 there was another announcement by Mr Elston, the minister of the day. Mr Elston announced 25 health care professions which would be included in a new provincial regulatory system to replace existing legislation. He announced that seven professions would become regulated for the first time. When we use the term "regulated" in this context, we are talking about self-governance. The professions would be audiology, dietetics, medical laboratory technology, occupational therapy, respiratory technology, speech-language pathology and midwifery.

At the same time Mr Elston made this announcement, he also talked about the things that were going on in the review at the time and he pointed out that the review team was again trying to answer the questions: is regulation by the Minister of Health appropriate, is regulation necessary, is regulation possible and is regulation feasible?

He listed those professions that would continue to be regulated. He named chiropody, chiropractic, dental hygiene, dental technicianry, dentistry, denture therapy, massage therapy, nursing, ophthalmic dispensing, optometry, osteopathy, pharmacy, medicine, physiotherapy, podiatry, psychology and radiological technology.

He also made reference to a group which is currently regulated, naturopathy, pointing out that in the opinion of the review team it did not meet the criteria for continued regulation. He also mentioned that the review team would move to the second phase of the legislative review, which

would attempt to define the scope of practice of the various health professions and address other issues that arose from the decision to regulate.

Slightly later, in March 1987, Mr Elston made another announcement. This one concerned the professions of dental hygiene and nursing. He indicated that a decision had been made that dental hygienists would have their own governing body under the new scheme and the College of Nurses of Ontario would continue to regulate both registered nursing assistants and registered nurses. In his statement he pointed out that there were significant differences between registered nursing assistants, for example, and dental hygienists to justify different regulatory structures. I think you will probably hear something further about these issues as we get into specifics.

Then, on May 7, 1987, Mr Elston made another announcement, which was that the Health Professions Legislation Review had been instructed to develop legislation that would, in most cases, open hearings involving self-governing bodies for the health professions to public scrutiny. The principle of accountability was mentioned as a fundamental principle to be observed. The notion was that by making the process more open, the professions would be more accountable in the public eye. At that point, Mr Elston also referred to proposals to open the activities of governing bodies to the public which had been made by the review team in a document prepared in October 1986 for circulation to the interested parties.

Before continuing, I just point out here that this is some of the documentation assembled by the review team. It is pretty weighty and we obviously did not copy everyone in on this. If we had brought everything it would have filled a truck, literally, when the review team finished its work. My branch became responsible for implementing bureaucratic support and trying to develop draft legislation for the government. We inherited the review team's files and they literally did fill a truck. I would point out that the public documents from that exercise have all been placed in the Ministry of Health's library and are available to one and all, so much of this documentation is readily available to the public.

It covers a wide range of things. There is a survey of health professional legislation in other jurisdictions. For example, there is Working Out the Details, a workshop that was held with participating groups. There are some famous publications here, red books and green books which are well known to the participants in the review. This was the kind of material that was sent out, along with that list of correspondence that I pointed out earlier, eliciting specific feedback from the participants to the review on a specific set of proposals. There is a wide range of other documentation as well. I just wanted to point out that the review team did spend an awful lot of time thoroughly looking at various aspects.

By the end of 1988 the review team was able to make its final recommendations to the Minister of Health at that time, who is the chair of this committee. It came in the form of a report called Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions. It was in the form of draft legislation, because that is what

the review was asked to do. However, it was made very clear, when the minister tabled legislation on January 26, 1989, that these were simply proposals from the review team and were the result of six years of work. In this document, in addition to the specific draft legislation there was an introductory portion. On the left-hand side of each page was some explanation for the rationale for the changes that were being recommended by the review team.

Then, as I said, on January 26, 1989, Minister Caplan introduced and tabled the report of the review in the Legislature. Some things are worth quoting from that statement: "Protection of the public will be the primary objective of any legislation I introduce," she said. "More than 200 groups involving approximately 75 health professions have already participated in the consultative process.... More than 7,000 pages of submissions were received and the review published eight major discussion papers."

Then on June 6, 1990, the next statement in the folder appears and it is the actual introduction of legislation based on the recommendations of the review. Prior to this introduction you will recall that I said there was no parallel process within the ministry. When the receipt of the report occurred we put in place a bureaucratic process by which virtually anyone who wished to comment on these recommendations was heard. Over the course of the next year and a half or so Linda and I had some 350 meetings with individual professional groups, be they the governing body or the voluntary association, individual practitioners, consumer groups, individual consumers. I do not think we could even count up the number of telephone calls we answered and the number of letters, but it was certainly very sizeable.

As a result of that we were able to provide assistance to the government of the day. The government of the day also had a political-level process whereby the chair of this committee had over 60 meetings with professional governing bodies and voluntary associations and major consumer groups to hear at first hand their feedback on the recommendations.

The result of all that was a distillation of all this feedback and the government was in a position to make some decisions about the actual content of legislation proceeded with the legislation and the next statement in your package, still under tab D, is the statement of the minister, Mrs Caplan, on June 6, 1990, on first reading.

In that statement there were a couple of things that were announced. She mentioned that quality assurance requirements had been incorporated into the package. She also talked about the basket clause, or the harm clause, which we heard about earlier, subsection 27(4), and the fact that it had been removed. It was the intention of the government of the day to introduce wording for a new clause. That was mentioned. She talked about an exemption through regulations for attendant care to assist people who were perhaps less fortunate to receive assistance with the activities of daily living.

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She also talked about naturopathy, making the announcement that while the question of naturopathy remained unresolved, it was the intention of the government to not

deregulate naturopathy and to refer the question of the scope of practice of the profession to the Health Professions Regulatory Advisory Council, which is to be created if this legislation is passed.

She also announced that there would be an interim Health Professions Regulatory Advisory Council to assist with the transition to the new scheme.

The next announcement was on April 2, 1991. The minister of the day, Evelyn Gigantes, retabled legislation not a great deal different from what had been submitted to the Legislature by the previous government, again talking about the tremendous amount of work that had gone into the preparation of the legislation based on the review's recommendations, with no fundamental deviation from the recommendations of the review team.

In the course of that presentation, Ms Gigantes announced that the government intended to bring forward amendments to increase public membership to just under half on the governing bodies, and also to double the number of public members, or non-professional members, on discipline committee panels within the colleges from one to two. She referred to the basket or harm clause and stated that the government did not intend to include it in the legislation, that the government was convinced that the controlled acts provided ample protection, based on the evidence it had heard to date.

In that announcement there was also mention made with respect to naturopathy, that it would continue to be regulated under the Drugless Practitioners Act, and that the question of the profession's scope of practice would be referred to the health professions advisory council. I must correct a mistake I made. In the earlier announcement the previous government had stated that the matter of their continued regulation would be forwarded to the council and, in the most recent statement on first reading, the question of the scope of practice would be referred to the advisory council.

Also, reference was made to amendments or exemptions for personal care attendants and for acupuncture. These would exempt those activities from the controlled acts scheme, essentially putting them in the public domain.

Ms Gigantes said that she would direct the advisory council to conduct a review of the operation of the legislation to take place five years after it came into force.

The last announcement in tab D is notes for a presentation made by the current minister, Frances Lankin. Ms Lankin referred to those particular comments earlier this morning, so I certainly will not repeat them.

The next section in the briefing book is section E, and these are the criteria for self-regulation. We thought it would be valuable to spend a little bit of time on this, because these are the criteria that were developed in consultation with the participants in the review. I am going to paraphrase here, but essentially and simplistically, the review team said: "What are the rules by which you would like to be judged yourself? What is fair? What is equitable?" I think it is safe to say that there was not unanimity, but there was consensus that these were fair rules. They are the rules by which the review looked at this massive input it had received, so that halfway through its six years

it could make specific recommendations about who should and should not be regulated. It applied these criteria to the submissions that had been received.

The first criterion is "Relevance to Minister of Health: A substantial portion of the profession's members are not engaged in activities under the jurisdiction of another ministry and the primary objective of the treatments they perform must be the promotion or restoration of health." So the profession had to be relevant to the Minister of Health to be self-regulated under a health framework.

The second criterion that the review team applied was "Risk of Harm: A substantial risk of physical or emotional harm to individual patients arises in the practice of the profession." It is also worth noting that in its final report, the review team stated that the bottom line essentially was number two, that the purpose of regulation was to protect individuals from harm, not to provide protection for status or monopolies or image.

The third criterion is "Sufficiency of Supervision," and the criterion is, "A significant number of the members of this profession do not have the quality of their performance monitored effectively either by supervisors in regulated institutions, by supervisors who are themselves regulated professionals, or by regulated professionals who prescribe this profession's services." In other words, there was no alternative regulatory system for one that was affected.

Number four takes that idea somewhat further to the existing framework and other things that could be considered, and that is the existence of alternative regulatory mechanisms. The criterion is, "The profession is not already regulated effectively or will not soon be regulated effectively under an alternative regulatory mechanism." When we get into specific issues, and in some cases profession-specific issues, you will find there are controls on certain hazardous activities under other statutes than the governance for the health professions in that specific legislation.

The fifth criterion was "Body of Knowledge." This too is another very important criterion and led to a number of significant decisions by the review team. This criterion states, "The members of this profession must call upon a distinctive, systematic body of knowledge in assessing or treating their patients, and the core activities they perform must constitute a clear, integrated and broadly accepted whole." We talked about naturopathy a little bit, and it was this criterion that was the most problematic for the review team during its hearings, because the information brought forward to the review by the profession did not allow the review team to make a clear decision in this area with respect to their saying without reservation that they have an absolutely clear, integrated and broadly accepted whole in terms of their practice and a distinctive body of knowledge.

Subsequent to the review, the profession brought forward additional information and presented it in a different way, which persuaded two successive governments to deviate from the review's recommendation in this regard. But the core of a profession is its body of knowledge, and without a significant body of knowledge, one can ask the question, how could a profession develop standards of practice, how can it govern itself if it does not have a body of knowledge that is unique to that group? If it is not

unique to that group, then maybe it should be governed somewhere else.

The sixth criterion dealt with educational requirements for entry to practice, and it stated, "To enter the practice of this profession, the practitioner must be required to obtain a diploma or degree from a recognized Canadian educational institution."

The seventh criterion was the leadership's ability—that is the leadership of the profession—to favour the public interest. The criterion reads, "The profession's leadership has shown that it is able to distinguish between the public interest and the profession's self-interest and in self-regulating, will favour the former over the latter."

The eighth criterion is "Likelihood of Compliance." The criterion reads, "There is enough willingness among the members of this profession to acquiesce, at least, to self-regulation that widespread compliance is likely."

The ninth criterion was "Sufficiency of Membership Size and Willingness to Contribute: The practitioners of the profession are sufficiently numerous to staff all committees of a governing body with committed members and are willing to accept the full costs of self-regulation. At the same time, the profession must be able to maintain a separate professional association."

The review team applied these criteria, and the next piece of paper under tab E is the first cut. Some 75 groups sought self-regulation before the review, and by applying these criteria the first cut resulted in—I think there are 39 here. These were basically professions that met a substantial number of the criteria, but where there were remaining questions that needed to be asked. The review team was able to go forward with this list.

The ones that were dropped from the list did not meet sufficient criteria, in the opinion of the review team, to warrant continuing in the process.

The Chair: It is important for the committee to note that it is 12 o'clock noon. Is it the wish of the committee to adjourn now until 2 o'clock or continue on to a certain point in this presentation today? Any direction?

Interjection.

The Chair: The presentation is going on all day. You want to complete to the end of section E?

Ms Haeck: That is right.

The Chair: Agreed? Okay.

Mr Burrows: Finishing off section E, there are a number of pages, and these are here; for example, the identities of the various groups we felt were not that important. These are working papers from the review. It will give you some indication of the way the review team went through this information that had been brought to it and applied the various criteria.

If you look at the first page, for example, at the bottom of the page that says number nine and the topic—the criterion they are looking at is numbers—it says that the profession they were looking at argued that a "history of self-regulation proves their ability in spite of low numbers." But the review team concluded that it could not believe that this group "alone, or in combination with" another group "currently have enough members to be fully self-regulating," that they could not staff the committees, their responsibilities, complaints and discipline and so forth, or fund self-regulation.

I will not go through the other pages, but these are other examples of the review team looking at how these groups did or did not meet these nine criteria. For example, the second page, looking at risk of harm, the statement is made that the review accepts the argument that group such-and-such "may pose a risk of harm." It talks about some of the things they do and some of the techniques this particular group is involved in—a large amount of detail. Again, the information is essentially coming from the professions themselves in response to questions, constantly refined questions, constantly more detailed answers, and then in the end these criteria are applied and the review makes a set of recommendations based on the application of those criteria.

That brings us to the end of tab E. I guess it is the wish of the committee we stop there and continue after lunch.

The Chair: Is it the wish of the committee to ask any questions prior to breaking for lunch on what we have heard up to the end of section E, or do you want to hold that until we come back after the lunch break?

Mr J. Wilson: Hold.

The Chair: Hold? We will adjourn now until 2 o'clock and reconvene. We will, as far as procedure is concerned, determine at that point when we want to be able to ask questions of Mr Burrows, at which point in his presentation.

The committee recessed at 1203.

AFTERNOON SITTING

The committee resumed at 1408.

The Chair: Are we ready to begin? The committee is now in session. With agreement, as all three whips are here—it has been standard convention at these committees to begin at the appointed hour or as soon as there is one representative from each of the caucuses present to constitute a quorum. Is that acceptable? Thank you very much.

We left off at the end of section E, and there was going to be some discussion about at what point the committee wanted to be able to ask questions. If it is acceptable to all the committee members, please signal me if you have a question and just let me know whether you want to ask it immediately, if something that Mr Burrows or Ms Bohnen says provokes you. If not, I will hold it until they finish the next tab, if that is acceptable.

Mr Burrows: We are starting again at section F, tab F. This is simply a list of those professions that are proposed for regulation. Once again I would remind you that when we use the term "regulation," we are talking about self-governance.

Each of these professions, if it is regulated, relates to a specific piece of legislation that governs it. I will not go through the whole list, but as an example, looking at the first, audiologists are not currently regulated. You will recall that is one of the lists I read out earlier. That basic list of who would and would not be regulated has not really changed since the review's recommendations, with the exception of naturopathy, which I mentioned earlier as well.

As you go down the list, you will see that chiroprodists have the Chiroprody Act, which dates from 1944. The chiropractors are under the Drugless Practitioners Act, dental technicians under the Dental Technicians Act, dental hygienists under the Health Disciplines Act, dentists under the Health Disciplines Act, denture therapists under the Denture Therapists Act, etc. There are eight separate pieces of health professions legislation. Again, that is one of the reasons the review was called, because it is all over the map in terms of its age, its composition, and different sets of rules for different groups of health professions. That in itself has created kind of hierarchy over the years, which is one of the things the review attempted to try to eliminate through its recommendations.

If we look at tab G, this is another list of criteria, which is very important. This was used by the review team to look at the controlled acts, the so-called licensed acts. Linda will be talking at some length about the scope-of-practice models, so I will not dwell on that other than to remind you that the basic scope of practice as contained in this set of bills would base registration for each of the health professions on a different model. The only thing that would be licensed or controlled would be a set of potentially hazardous activities.

In deciding what should be on that list, the review team proposed some specific ideas, and those ideas were again based upon the application of a set of principles to the material at hand. So there is some material here from the review itself. At various times during the process, the re-

view brought forward for policy direction various options, and some of the material in this brochure comes from those presentations. You will note, for example, that at the bottom of the page, the first item under this section, it says, "Health Professions Legislation Review." Anywhere you see that, you will know it is one of the review's original briefing documents.

The first such page is headed "Listing licensed acts will establish clearer limits on the exclusive practice of regulated health professions." These are the review's opinions, I would remind you, as opposed to legislation, but they are worth repeating.

The review team said that "licensing acts will reflect current practice of governing bodies to enforce their broad licensure provisions selectively, generally focusing on specific acts." It went on to say that "articulating licensed acts will provide better definition of the border between exclusive and non-exclusive practice."

Then they made three points: the first one, that "governing bodies will be better able to enforce their licence provisions against unregulated practitioners"; second, "the courts will have better guidance when determining the extent of professional monopoly"; and third, "unregulated practitioners and regulated practitioners without explicit authorization to perform certain licensed procedures will better understand the limits of their own practice."

They continue by saying that "licensing specific acts will allow increased flexibility to share exclusive acts between professions with fewer turf battles because the act will be explicitly recognized with each profession's scope of practice."

The last point on this page is an important one in terms of public policy. It says that "governing bodies will be encouraged to promulgate standards of practice for each licensed act which may restrict the performance of the act to specially qualified members."

The tests or the criteria that were applied to determine whether an act or an area of practice should be licensed are on the next page. It is again worth looking at each one.

The first point is that "the nature and extent of harm either inherent in the act or when the act is applied to select populations must be significant." So the first criterion was relevant to the significance of the risk of harm.

The second test as to whether the act should be licensed is that "licensing acts must be a more appropriate response than institutional or other controls."

Third, "the act must be practised without direct supervision or supervision exercised through institutional protocols," such as, for example, the rules that might apply in a hospital.

Fourth, "the prohibition imposed from licensure must be enforceable." One of the criteria the review team used was that you cannot just have an act or a control; it has to be realistically enforceable.

Fifth, "practitioners must be adequately trained in current educational programs to perform the act."

Sixth, "prohibitive costs or unreasonable rigidities in the system should not be imposed on the health care system."

The next page is a working document. This is a list of the proposed licensed or controlled acts at one point during the review process. It is quite different from the final list and is here only to serve as an example to show you that this list did evolve as information came forward and as the criteria or tests were applied.

Section H is the actual list of controlled acts. Again, I will not repeat each and every one of these, but I will use a couple as examples. Most of them are very concrete; they deal with specific activities. Number three, for example, is "setting or casting a fracture of a bone or a dislocation of a joint"—straightforward.

But if you look at number one, this is a cognitive act and, essentially, this is the legislation's attempt to capture the notion of a traditional kind of medical diagnosis. It reads as follows: "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion." This is the one we heard about this morning. It is one that Linda will come back to, when we are talking about issues, to explain in more detail. But that is the actual wording of the proposed licensed act.

We have a complete list, if you will turn over the pages, right down to 13. Number 12 is "managing labour or conducting the delivery of a baby"; 13 is "allergy challenge testing of a kind in which a positive result of the test is a significant allergic response."

One of the interesting observations: Towards the end of the review process and during the consultative phase within government after the receipt of the recommendations, virtually everyone was asked a similar question. It was: "Is this list complete, and can you or can you not add to this list if you think it is not complete?" Suffice it to say that from the review team and subsequent to the receipt of the review's recommendations, no one has made a substantial suggestion as to how this list should be altered. There is general consensus that this list of generic acts, although it certainly does not describe in great detail, does capture, generically again, the body of potentially hazardous acts that meet the tests applied by the review team.

I have last item related to the review before Linda takes over, and that is under tab I. One other issue that you are going to hear a lot about is title protection, and this again comes from the review team. The review said that "the key concern is the use of qualified titles using words such as 'registered' and 'certified.'" I think Linda is going to talk a little bit about the difference between registration and certification. It is an important distinction.

"The review's proposals have been contested by professions who are motivated in part by: status concerns; an attempt to create or maintain an economic monopoly; the desire to do indirectly what has been directly prohibited." I would remind you again that this is the review team speaking here. "Another issue involves protecting reference to

the profession (e.g. audiology) as well as the professional (e.g. audiologist) as part of the protected language."

Finally, the review team said, "A few professions have suggested that the 'holding out' provision in the legislative proposals may not provide sufficient protection from non-registrants using close derivatives of the protected title." We will be hearing a lot about this in the weeks ahead, and we thought it was important that you see the review's general feelings on the subject. The "holding out" provision we talk about is when someone holds themselves out to be something; for example, holds themselves out to be a nurse or a physician or a physiotherapist.

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Ms Haeck: Mr Burrows, over the last few weeks I have received some correspondence from people working in academic institutions who hold doctorate degrees; they have a concern that they will not be able to use the title "doctor." Do you have any comments to make on that?

Mr Burrows: I will make a very brief one because Linda is going to be talking about this under the actual issue and she will go into it in as much detail as you would like. Essentially, the control on title would apply only in the health care setting; it would not preclude people from identifying themselves as PhDs and so forth. Linda will explain that in detail. It definitely relates only to particular health care settings as opposed to the general use of the title.

The Chair: That takes us to the end of section I. Any questions at this point? Ms Bohnen is going to continue.

Ms Bohnen: I would like to start by outlining the two fundamental aspects of the regulatory model incorporated by the legislation.

First, if I could direct you to the second sheet in tab J, I want to talk a little bit about this being a model of self-regulation or self-governance.

The sketch on this page is an attempt to depict visually the legislative framework within which the colleges at the centre of the piece regulate their own members; they also have important interactions with patients or clients of members and, to a more limited degree, with others such as hospitals or other employers of health professionals.

Then above the colleges, at least visually above them, are the Ministry and the Minister of Health with their own responsibilities, powers and duties vis-à-vis the colleges.

Off to the side are the courts, the Health Professions Board and the Health Professions Regulatory Advisory Council, which you have already heard something about, at least vis-à-vis the council, which also have a role to play in the regulatory framework.

This legislation puts in place the structures, the rules of procedure and the legal principles by which this entire structure operates. It is a system of self-regulation or self-governance.

This might be a good time to address an issue that is very important to the discussion of self-regulation: the minister's powers. A question was raised about that this morning, and I think you have heard or will be hearing from some groups which feel that the way the minister's powers are expressed in the Regulated Health Professions

Act may compromise self-regulation. At least it is perceived in that way.

In fact, the nature of the minister's powers was discussed in some detail in the review between these infamous green books and red books. While I am on the subject, I might just hold it up to demonstrate that the proposals the review generated were printed and distributed to all participants.

In this green book it took place in October 1986, and what you see here—we can circulate this—is a very early, primitive draft of a Regulated Health Profession's Procedural Code. After this was circulated to participants, and all their written and oral submissions were received, another version of it was published in the red book in June 1988, with commentaries that reflected the changes made by the review on the basis of the submissions that had been made. Finally, the submissions on the red book were what led to the final modifications in the published turquoise book, "Striking a New Balance".

Among the provisions that were modified through this process were the minister's powers. In fact, one important power which the review proposed in the green book was dropped from the red book. That would have been the power given to the minister to inquire into, or direct a council or committee of a college to inquire into, any matter related to the practice of a member or members of a profession.

That would have given the minister, for example, the power to require a discipline hearing to be held in relation to a member. Many groups felt that would have undermined self-regulation and procedural safeguards so that was dropped and did not appear in the red book.

Some other powers the minister would have had, to direct committees to take certain actions as well as the council itself—the council being a little board of directors of the college—were also dropped between the green book and the red book. The review responded to submissions from groups that it was very important to preserve self-governance and the appearance of self-governance.

Finally, in the green book, the minister was given the power to require councils to undertake activities that were necessary and advisable to implement this legislation. The word "require" was used: may "require" the council. That word was used in the green book. It was changed to "request" in the red book, but it was coupled with a provision which, in essence, said it may be a request but the minister can require a college to comply with it within a set time. It was a funny kind of request.

However, legislative counsel said: "We don't do it that way. If we mean 'require,' we say 'require.'" So the word "require" was restored in the bills. I think that seemingly innocent change from "request" to "require" is generating some of what you may be hearing about the minister's powers in the legislation.

Two other points it is important to make, or one other point, as I have mentioned the degree of consultation that has gone into this procedural code and the structures: The title "Striking a New Balance" in the reviews and recommendations is a very significant and important one. It may not matter very much whether a word is changed in one

particular provision here or there, as long as this balance is maintained, because it is a balance that has been developed through some six years of negotiation and consultation. It is a balance that the majority of interest groups continue to support, and it is a balance, I think, which two governments have felt would achieve the result of effective self-regulation.

I hope that sketch has shown you the structure that all of these individual procedural provisions relate to.

Mr Beer: Could you give us a specific example, if this were passed and became law, of something a minister could do that she cannot do today? Does it mean simply that under this she would have the authority to require that certain things be done, and that at the present time she cannot? What are we dealing with here?

Ms Bohnen: I am not sure we are dealing with a whole lot that is different. For example, currently under the Health Disciplines Act the minister has the power to request a council to make, amend or revoke a regulation. Then there are related provisions which go on to say that if they do not make the regulation within, I believe it is 60 days, the government can make the regulation for them.

Mr Beer: This would be a direction, for example, to the College of Physicians and Surgeons; so today she could say, "Thou shalt do such-and-such," and if they do not, under the present act—

Ms Bohnen: She would say, "Would you please make a regulation?" and they would probably say yes—it does not happen very often. But if they said no, then she would say, "Okay, if you don't make it within 60 days, the government will make that regulation."

Mr Beer: So that is possible under the existing—

Ms Bohnen: Yes, it is.

The Chair: There was an example of that in 1982.

Ms Bohnen: It was a regulation dealing with extra billing, as I recall.

The Chair: I believe the minister of the day asked the College of Physicians and Surgeons to draft a regulation that would require the posting of information regarding extra billing to patients. The college said, "No, we would rather not make the regulation," and 60 days later the minister did. I believe that is correct.

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Mr Beer: The reason for my question is just that I want to be able to understand better why some people are raising questions.

Ms Bohnen: We have had meetings with some of the groups raising the question. When pressed they have said: "Yes, we know the substance of the powers is more or less the same, but we really prefer the word 'request' even though it's clear it's a mandatory request. We just don't like that word 'require.'" That regulation example is a clear instance of it. The Health Disciplines Act uses the word "request" with a provision saying that you have to comply within 60 days. This bill says "require."

Mr J. Wilson: I have not read the schedule 2 disciplinary section, but what would the minister's involvement be in discipline in the professions? Final appeal?

Ms Bohnen: No, the minister, in fact, has no role to play. The professions are responsible for disciplining their own members and the minister has neither the power to require the college to conduct a discipline nor does she sit in appeal from a discipline decision.

Mr J. Wilson: So it does not change from its current status.

Ms Bohnen: That is correct, whereas one of the early proposals of the review would have changed that quite dramatically. It would have empowered the minister to require a college to discipline a member.

Mr Beer: Can I qualify that? There is still the right an individual would have to go to the courts, as in the Steven Yuz affair?

Ms Bohnen: Yes, there is an appeal to the Divisional Court from a decision of the discipline committee.

Mr Beer: And that remains.

Ms Bohnen: Yes, that remains.

Mr Callahan: The appeal to the Divisional Court would only be on the jurisdictional question, would it not?

Ms Bohnen: No, it is not judicial review. It is an appeal on a question of fact or law or both. It is a full appeal.

Mr Callahan: That is set out in the legislation?

Ms Bohnen: Yes. Subsection 68(1) of the procedural code says, "A party to proceedings"—and I will just pick out—"before a panel of the discipline...committee...may appeal from the decision of the...panel to the Divisional Court." Subsection (2) says, "An appeal under subsection (1) may be made on questions of law or fact or both." That is essentially the same as the Health Disciplines Act appeal provisions, unlike the situation under some of the other statutes where there is only judicial review.

The most innovative part of this legislation lies in the area of regulation of scopes of practice, or who can do what. If you turn to the next page in the same tab section, on the back of the previous page we see that this legislation determines the activities that can be performed by various practitioners, both regulated and unregulated. So it answers that important question, who can do what, but it answers it in a way that is quite different from existing legislation.

I would like to explain that by taking you back to what the existing legislation provides. We try to depict it in the drawing which is in your material; it shows two circles. Under current legislation, practitioners, like physicians, have what is referred to as an exclusive licence to practice. Any service within the scope of practice of medicine is restricted to physicians.

There are exceptions to that through delegation and other specific statutory provisions, but in general terms it is correct to say that if something falls within the scope of practice of medicine, only a physician can do it. We have depicted that with this large outer circle.

We know that if you analyse the functions that physicians perform, some of them are quite hazardous, such as

surgery or performing X-rays. Other activities are not hazardous at all, things like conducting a physical examination, taking a history, taking a blood pressure, counselling and so forth. But all those activities under the current legislative model are restricted to physicians because they fall within their scope of practice.

What the review tried to do was come up with a new way of saying who can do what that did not depend on the idea of exclusive scopes of practice, but rather just identified hazardous functions, hazardous areas of practice and procedures, and said, "Those hazardous things we are going to closely regulate, but anything else, anything in the nature of an assessment, in the nature of counselling, a huge number of pretty low-risk activities, we're going to leave in the public domain as much as possible." That thinking is what ultimately led the review to invent the list of licensed or controlled acts that Al showed you a minute ago.

You have to grasp the difference between the old model and the new model to make sense of this legislation, so I am going to try to go over it in a couple of different ways to try to make it clear.

Mrs Cunningham: Just before you go any further, so I can grasp it, when you talk about low risk—I cannot remember the words but you said it twice—you talk about medical examinations and you talk about counselling. Would you describe to me what you mean by low risk so I can grasp it, because I consider both of those, myself, to be very high risk, from what people tell me.

Ms Bohnen: Perhaps I can approach an answer by telling you how the list of high-risk and therefore controlled activities was generated. That was done by asking the professions who were involved in the review to itemize the procedures or activities which they thought were the most dangerous things they did.

Mrs Cunningham: Dangerous in what way?

Ms Bohnen: That might cause significant physical or mental harm. So the first cut was just a list. The review asked them, "Write down everything you do that you think can cause significant physical or mental harm." The list was quite long.

Mrs Cunningham: I bet.

Ms Bohnen: The review then applied the criteria that Al reviewed a short time ago to try to select out, for example, those which were adequately controlled through some other mechanism. For example, X-ray is already controlled in Ontario through the Healing Arts Radiation Protection Act. It also separated out those which, when you really analysed it, did not seem so hazardous after all, but for which there seemed to be some other interest, perhaps an economic interest, motivating the desire to say it was very hazardous. Also, they applied, I think, a large dollop of pragmatism, realizing that some activities, although they may potentially be somewhat hazardous, are impossible to control. I think counselling is probably the best example of that, because counselling is just so widespread. So many different occupations provide it.

Mrs Cunningham: But is that not controlled in what you described as "in some other way"?

Ms Bohnen: Counselling? I guess some of it is, but a lot of it is not. Think of everybody from MPPs in their constituency offices to the clergy, of course, and teachers.

All sorts of counsellors without the benefit of regulation practise in Ontario. It was felt it was logistically impossible to control it, to limit who can provide it. It may be that they also felt there was not sufficient evidence of significant actual harm being done, or at least harm that would outweigh the need to have readily available counsellors of many different kinds.

Mrs Cunningham: What you said today is certainly sufficient for me at this point in time. We can maybe ask some of the witnesses the questions that flow from what you have just said.

On the other one, though, this medical examination—you have answered the counselling one—when you said that, did you mean that others would in some way do medical examinations, other than physicians? Did you have that in mind or is that something that we should be thinking about?

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Ms Bohnen: A good example is the nurse practitioner—a member of another regulated profession, obviously—who is qualified, trained, to provide many kinds of assessments, well-baby assessments and so on.

Mrs Cunningham: So that is an example of something that is regulated in another way?

Ms Bohnen: Nurses are not physicians, and currently, of course, they are not licensed to practise medicine. Some would argue that the kind of physical examinations and assessments they perform is darned close to the practice of medicine, but it is clearly very desirable for them to be able to do that, and they are a member of a regulated profession.

Mrs Cunningham: That is what I meant. Okay, for the moment.

Ms Bohnen: All right.

The Chair: Mr Callahan.

Mr Callahan: I am interested in what you said about enlarging the scope of what was exclusively the bailiwick of somebody else where it is not a hazardous item. Yet I look at section 4, paragraph 2 of the Chiropractic Act, Bill 46, and it talks about "moving the joints of the spine." That is surely a reduction in the available techniques that a chiropractor can carry out now. He can flex limbs. Why is that gone? And does that not fly in the face of what you are—

Ms Bohnen: You have pointed to an element of the regulatory model, but not the controlled acts. Flexing a joint is not a controlled act to begin with, so you cannot say it is taken away from a chiropractor.

Mr Callahan: But it says, "In the course of engaging in the practice of chiropractic, a member is authorized...." So I gather that is what he or she is allowed to do, and it strictly limits it to the joints of the spine.

Ms Bohnen: It does not strictly limit it. I think it really might help if I went through the elements of the regulatory

model to make it clearer how this fits together, if I could do that.

Okay. The intention was to come up with a system that would protect the hard core of hazardous activities that ought to be strictly controlled, but free up in the overall health care system the performance of relatively low-risk activities. So how do we do that? First of all, every profession is given a statutory scope-of-practice statement that describes what the profession does, the methods it uses, the purpose for which it does it, but does not restrict to the profession the activities within that description. It is just a description. It has many uses within the health care system, the education system, for employers, for patients and so on. But it does not create a monopoly or an exclusive area of practice. It is really a descriptive use only.

Coupled with the scope-of-practice statement is the list of controlled acts you saw earlier in the book. If something is not on that list of 13 categories of controlled acts, anybody can do it. So when a chiropractor, or any other practitioner, says, "Am I going to be able to do such-and-such?" the first place you look for the answer is to section 26 of the Regulated Health Professions Act, which sets out exhaustively the master list of controlled acts. Anything in those 13 categories that are listed in subsection (2), provided it is done in the course of providing health care service, is controlled. So if something like moving a joint is not on that list, then you have your answer: The chiropractor or anybody else can do it, because if it is not on the list, it is not being taken out of the public domain to begin with.

Mr Callahan: It is on the list, though.

Ms Bohnen: Not a joint.

Mr Callahan: Well, section 26, paragraph 4, says, "moving the joints of the spine."

Ms Bohnen: "Of the spine." That is spinal adjustment.

Now, if something is on that list, then the second stage of the inquiry is, "I'm a nurse," or "I'm a chiropractor," or I am a whatever: "Can I do it?" To answer that question, you have to look at the Chiropractic Act, the Nursing Act, etc, and look in the relevant section of the act to see what the authorized controlled acts of nursing, chiropractic, etc, are.

To focus on chiropractic, they want to know, "Can I manipulate the spine?" Start with the spine. We see from paragraph 26(2)4 that "moving the joints of the spine beyond the individual's usual physiological range of motion," etc, is indeed a controlled act. We then move to Bill 46 and see that, in section 4, paragraph 2, chiropractors are authorized to move the joints of the spine beyond a person's usual physiological range of motion. So that is how we track through the legislation to see who can do what. Okay?

Mrs Cunningham: Just to follow up on Mr Callahan's question, my understanding is that that is what they are doing now, but they are doing more than that now: They are doing shoulders and wrists and knees and necks.

Mr Callahan: What she is saying is they are still likely to do that, but it is not under this controlled act section.

The Chair: Mr Callahan?

Mr Callahan: We would only worry about the spine.

The Chair: For Hansard, you are identified first, so if there is going to be conversation between the committee, just signal, and I will mention your name.

Mrs Cunningham: So you are saying they can still do that?

Ms Bohnen: Yes. What they are concerned about has to do with the diagnosis of conditions of the joints that are not related to the spine, but I do not believe that they are concerned about—it is not my information, nor what I understand why they would be concerned about their ability to continue to manipulate these joints, because the only kinds of manipulations being controlled in any event are spinal manipulations. Okay?

Mrs Cunningham: Well, from a consumer's point of view, the big problem there is, does one have to be referred now to a chiropractor by someone who has diagnosed? That was my first question. My second, diagnose, let's say, the neck. Or would the better question be, no, they do not have to be referred now nor will they have to be referred in the future. If so, who has made the diagnosis?

Ms Bohnen: The neck is pretty much the spine, so I am not sure it is the best example.

Mrs Cunningham: Let's use the knee.

Ms Bohnen: All right. A person does not now need a referral from a physician to go to a chiropractor, nor will there be anything in the legislation to require a referral in the future. If you go to a chiropractor with a knee problem—I mean, the patient does not know what the knee problem is; they just know they have a knee problem—the chiropractor, under this bill as it now stands, may diagnose the problem of the knee if that problem has a connection to a problem of the spine or the effects on the nervous system. Under the bill, though, if that problem of the knee has no connection whatsoever with a problem of the spine or a resulting problem of the nervous system, then the chiropractor may assess that knee problem and advise and provide treatment for it, or—and the chiropractor is trained to do this—the chiropractor may refer the person to a physician because he believes that the symptoms are such that this knee problem does need a medical diagnosis that the chiropractor cannot provide.

So lots and lots of problems can be assessed and treated without the necessity of a diagnosis, and people like chiropractors are trained to distinguish those from other conditions which do require a different kind of practitioner's diagnosis.

Mrs Cunningham: So the key words are "assess" and "diagnose." That is the difference?

Ms Bohnen: Yes.

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Ms Haeck: This is sort of dancing around the same point, and I want to be quite specific because I have had questions that were that specific, and that is relating to carpal tunnel syndrome. I think basically you have answered it in your answer regarding the knee joint problem, but could you actually tell me that this is exactly what you are saying? Sorry if I appear a bit thick, but I really would

like to make sure that I have it clear when I am talking to the practitioners in my area.

Ms Bohnen: I do not feel I know enough about carpal tunnel syndrome to know whether it is something that has any connection whatsoever to the spine or the nervous system, but let's assume that it does not. I do not know if it does or it does not, but we will say it does not. It is just a discrete condition that has no connection to a spinal problem or a spinal problem that affects the nervous system. In such a case, a chiropractor could assess his or her patient and decide that a particular course of treatment will be effective for this patient's set of symptoms, but could not conclusively communicate a diagnosis of carpal tunnel syndrome.

Mr Cordiano: For those of us who are somewhat ignorant, what is carpal tunnel syndrome? I have never heard of that term.

Ms Haeck: It is for those people who spend a lot of time doing repetitive acts, especially for people who are doing typing with computers, and usually it affects the hand. I have to say I am also not a medical practitioner of any sort—I guess we are all in that boat—just having had a few people in my office with workers' compensation problems around that issue. They obviously could speak to it in a much more enlightened fashion than I can, but it is related to repetitive acts. I cannot answer the question to what degree it affects strictly the nervous system or other—

The Chair: There might be a better approach to these more technical questions as they are raised. I am sure the clerk would have access to dictionaries. If there are terms or terminology which is raised, if you make a point, the clerk can get you the definitions, because I do not think anyone here is expert enough to be able to give the definitions without the assistance of those kinds of dictionaries. So we will make sure they are available, and if you will just make a point of asking, then we will make sure that you have that information.

Mr Beer: Clearly, as Mrs Cunningham underlined, the meaning of "assessing" and "diagnosing" is very critical to all of this, and what one gets from a number of practitioners who come to see us, when is an assessment a diagnosis or when is a diagnosis an assessment? In the way that you described some of those things, from a layperson's language, they are fairly similar. I do not know whether you are going to be dealing with those definitions a bit later, in which case I would say, let's leave it until then, but it seems to me that is one of the critical points, for those of us who are meeting with different groups, the concern about, "If I make an assessment and it is wrong, can I later down the line be held accountable for that as a diagnosis?" and around some concerns, as expressed to us, of the way in which some of those terms are used. It also gets into the dysfunctional, and I forget what the other words are.

Ms Bohnen: Disease, disorder, dysfunction.

Mr Beer: Right, and just what is, in legal terms, a dysfunction? What is a disease? What is a disorder? I think at some point we need to address those issues in terms of the meaning that is being ascribed to them in the act. I do

not know whether this is the point, but I just think Mrs Cunningham really—

Ms Bohnen: I think a useful time to come back to it is when a little bit later we get to the diagnosis issue, because it is really only in relation to the diagnosis controlled act that these distinctions take on significance.

Mr Beer: Okay.

Ms Bohnen: Because the scope-of-practice statements do not carve out exclusive areas of practice, from a legal standpoint they do not have a great deal of significance, and the scope-of-practice statements do not give anybody turf. It is the controlled acts that allocate the controlled acts and that do spawn the turf battles that are legitimately important areas for disagreement and debate. But with the removal of the harm clause, the scope-of-practice statements, which were very largely worked out among the review participants at the review and are widely supported by the majority of practitioner groups, do not have much technical significance any more, so I think that is one of the reasons why legislative counsel, who was not really permitted to redraft them very much, was content with that. From our technical viewpoint, they do not have a whole lot of significance any more, whereas the controlled acts do.

Mr Hope: Did I hear you correctly saying we are going to this diagnosis stuff a little later?

Ms Bohnen: Yes.

Mr Hope: It is the question of whether you have a heart attack or whether the signals show that you are having a heart attack, and it is the communication part that I think a lot of—even the nursing profession. They were very creative when they communicated to me. They talked about pregnancy and my wife and about midwifery. They talked about a heart attack patient coming in to the emergency ward with all the symptoms of a heart attack. You cannot say the person is having a heart attack, but everything is there showing a heart attack. When you talk to a doctor over a phone—and this is, again, rural Ontario—you are telling him everything that is there. You are just not saying, “Sorry, the person is having a heart attack right now.”

This is the communication and diagnosis, which I think a lot of people really do not understand, and as we talk more I think we confuse ourselves about this diagnosis and this communication, whatever you want to call it. This is where everything seems to be in limbo around this whole issue. If we are coming back to it—I would like to, later, because I am going to use some of the examples they have about my wife having a pregnancy, and some of this—let me tell you, it brought back memories, too.

Ms Bohnen: My preference would be to come back to it.

Mr Cordiano: First, get your wife’s permission to do that.

Perhaps this is a question that I should have asked the minister, but I thought I heard her say it is her intent that the harm clause would be removed. I just wondered at

what stage that was decided. Was it something that you just decided in the last little while—

Interjections.

Mr Cordiano: Okay, so that was back in April.

The Chair: That was in the documentation, the statement by the minister at the time, Ms Gigantes.

Mr Cordiano: My understanding was that she is leaving it open to be convinced otherwise, and it is a question that I think needs to be addressed because there are certain professions which would still like to see that introduced.

Ms Bohnen: What I heard her say this morning was that she had not yet been convinced—

Mr Cordiano: That it was necessary.

Ms Bohnen: —that it was necessary; that she had not heard anything to alter her conviction, the government’s conviction, that it was unnecessary.

The Chair: Continue, please, since there are no further questions at this point.

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Ms Bohnen: The new regulatory system abolishes the concept of an exclusive scope of practice, which is a very important change, and the next couple of pages were included because they demonstrate the distinction between a profession which has a licensed scope of practice, medicine, on the right-hand side of the page, and nursing, which in Ontario has never been a profession that has had an exclusive or licensed scope of practice. Nursing in Ontario has had the benefit of title protection, and we refer to it as a registered profession because of the title “registered nurse.” In professional regulatory literature you also hear the word “certified” being used; that if you belong to a profession that does not have an exclusive scope of practice but permits you to use a title that non-members cannot use, you belong to a certified or registered profession.

So as we see from section 75 of the Health Disciplines Act, “No person shall use the title ‘registered nurse’ or the designation ‘Reg. N’ or ‘RN,’” etc, unless the person is registered under the Health Disciplines Act. But the closest provision to giving nurses any exclusive area of practice is in section 86, which just says that “Every person, other than a patient, who employs a person as a registered nurse” must ensure that the person in essence is a registered nurse. So if a hospital employs someone in a position designated a nursing position, that person must be a registered nurse, but nothing whatsoever stops the hospital from deciding that a particular position need not be a nursing position; it can be a position held by, let’s say, a health care aide, because nurses do not have an exclusive scope of practice. That is to be contrasted to section 52 of the Health Disciplines Act, which says, “No person shall engage in or hold himself out as engaging in the practice of medicine unless he is licensed under this part.” So you cannot practise medicine without a licence. You can practise nursing without being a registered nurse, and that is the fundamental distinction under current legislation between registered or certified professions and licensed professions.

This distinction, which most jurisdictions have, is being eliminated by this legislation, and instead, every regulated

profession will play under the same set of rules. Every profession—nursing, medicine, dentistry, dental hygiene, etc—will have a descriptive statement of its scope-of-practice, coupled with certain authorized controlled acts.

Mr Beer: This relates back to something you said before. I do not want to put words in your mouth, but you said the absence of the harm clause, those scopes of practice, those definitions, and correct me if I am wrong, do not mean much or at least do not mean anything legally. When you say you have changed what we see here in front of us, what then is the significance of the scope of practice statement if it has no particular legal bearing?

Ms Bohnen: It does not have legal significance in terms of restricting people to certain areas of practice or in excluding others from areas of practice, but it has social significance and public policy significance in terms of signalling to educators what the curricula to produce a position should be; to employers, when they have a particular function that needs to be carried out—they should be looking at a speech pathologist or a physiotherapist; to manpower planners and so forth.

Mr Beer: So the protection of the public would be through the 13 controlled acts.

Ms Bohnen: Yes.

Mr Beer: Again, just because I want to make sure I understand, the way the legislation reads today without the harm clause, and that is one thing we are going to have to look at as to whether in our view there should be one and if so what kind or whether we agree with the minister, the protection for the public is through those 13 controlled acts, in effect.

Ms Bohnen: Public protection in terms of who can do what, but of course, other provisions such as title protection, quality assurance, etc, also protect the public.

Mr Beer: Fair enough. Yes.

Ms Bohnen: But in terms of who can do what, yes, it is the controlled acts that you look at.

Mr Cordiano: Following on the heels of that, given what you have just said, and you touched on the point of title protection, from the public safeguard point of view, it becomes even more important with respect to certain types of professions like speech pathologists or psychologists, for example. There are some problems associated with that and I know we will address them as we go on, but just to highlight the fact that title protection then becomes all the more significant, I think it has heightened the interest of those who feel their titles may be, not threatened, but shall we say somewhat confused by the public.

Ms Bohnen: I think title protection becomes more significant, but in two competing ways.

Mr Cordiano: Very much so.

Ms Bohnen: First of all, the public has to be able to identify a speech pathologist, a psychologist, because so much of public safety will depend on recognizing whom you are dealing with. But the public has to have access to complete information about unregulated practitioners as well, because part of the policy thrust of the legislation is to say, "Look, if it isn't hazardous, we should have more

competition in our health care system." Well, you cannot have effective competition if patients cannot get information about all the services available to them. What this has tried to achieve is to ensure, yes, that the public is assisted to identify psychologists, speech pathologists, etc, but at the same time that there are not barriers to the public obtaining adequate information about unregistered speech therapists, speech teachers, psychometrists and other kinds of counsellors.

The Chair: Thank you. No further questions?

Ms Bohnen: I would like you to turn to tab K, if you would, because the sheets that follow under the general heading of "The Balance in Each Profession" are sheets which summarize, I guess you could say in a nutshell, what each profession is getting and not getting from the legislation, and it compares that to what it now enjoys under existing legislation; or of course for those currently unregulated professions, how it sort of functions in the health care system without any legislation.

Starting with audiology, I would just like to take you through some of these to assist you in understanding what we meant by the subtitles. As you can see, audiology is not a currently regulated profession, so it has no existing scope of practice. It has no statutory title protection, but we see from this that the title "audiologist" is commonly used within the occupation.

Subheading II is what was proposed by the Health Professions Legislation Review, and sets out the general scope of practice statement and the controlled acts. When we say "proposed by HPLR," we are referring to Striking a New Balance, the turquoise book.

Item III, analysis, was an analysis provided by the review. When the review compared its recommendations for scope of practice and controlled acts to what the profession then had, it said, "Okay, what is it getting?" Well, it is getting statutory self-regulation; it is getting the licence to prescribe personal hearing aids—only audiologists and physicians will be able to prescribe personal hearing aids; and the review said that currently dispensing audiologists should be permitted to continue to dispense, ie, grandfathered.

What were they not getting, in the review's analysis? They are not getting diagnosis; they are not being permitted to dispense hearing aids everywhere; and they are not getting a prohibition on testing by hearing aid dealers. I would just like to remind you that this was the review's analysis of what the profession was getting or not getting from its recommendations. As we go through these I think you will see that most professions are getting some things and not getting other things. This reflects the balance that was struck.

Then the final subtitle on this page, "Changes in Bills," we added to set out in very summary form any major differences between the bills you have before you and the review recommendations. So you see here that there is no change in what they are getting, although in fact this issue of grandfathering of dispensing audiologists is, from the viewpoint of this legislation, really a non-issue. What are they not getting? Because of the way the title protections

have been redrafted, they are not getting the benefit of title protection outside the provision of health care services.

It is 3:10. I am sort of in your hands and in the hands of the Chair, but it might be worth while to go through these individually to give you a chance to ask any questions. Judging from the questions you have had so far, it might be useful to focus on getting and not getting and changes in the bills. Would that be useful?

Turning next to speech-language pathology, which is not alphabetical, but as you know, it is clustered in one bill with audiology.

1510

Mr J. Wilson: Could I ask a question on audiology?

The Chair: Sure. Perhaps we will do it that way. At the end of each one we will just see if there is a question and then move on.

Mr J. Wilson: They can prescribe hearing aids. What is the act of "dispensing"?

Ms Bohnen: Dispensing a hearing aid is what a hearing aid dispenser does when he or she sells to a customer the actual hearing aid.

Mr J. Wilson: That is what I thought.

Ms Bohnen: It may also include testing the person's hearing so that the appropriate hearing aid can be dispensed.

Mr J. Wilson: If I understand them correctly, we are getting letters from constituents complaining that they do not want to be forced to get their hearing aids just from doctors. They want to be able to get them from other practitioners.

Ms Bohnen: I am aware of several different types of letters you may be getting on this issue. Some letters may be saying, "We're concerned about only being able to go to an audiologist." I have not heard too many people say—

Mr J. Wilson: Sorry; I had it backwards.

Ms Bohnen: Under these bills you will be permitted to go to an audiologist or a physician for a prescription. The prescription may be a very generic one. If you need a hearing aid—this would likely be the case for most physicians—you would take the generic prescription to a hearing aid dispenser who has the equipment and the knowledge of how to test your hearing so that he or she can then dispense to you the appropriate hearing aid, whereas if you went to an audiologist, the audiologist would be able to test your hearing fully and I am sure would issue you a much more detailed prescription than a physician would.

I said grandfathering of dispensing audiologists was a non-issue. It is an issue in terms of conflicts of interest. In general, in Ontario legislation and regulations we try to prevent setting up a situation where practitioners who prescribe an item can then sell you that very item, because there is an inherent conflict of interest there. This legislation, because it does not control dispensing of hearing aids anyway, does not really address who can dispense. The Ministry of Health has another program, the assistive devices program, which has policies and rules in place to prevent conflicts of interest between prescribers and dispensers. But in this legislation, you will not see any rules

about conflicts of interest in dispensing and prescribing in these bills.

Turning to speech-language pathology, again a currently unregulated profession, what are they getting in the review's analysis? They are getting self-regulation. In the review's analysis, what are they not getting? They are not getting the right to perform the diagnostic controlled act.

Changes in bills: The only change is what we saw earlier with the audiologists, the change to the wording of the title protection. Other than that, these bills are the same for them as the review recommended.

Subheading V, "Other Issues:" For your assistance, I believe they will be proposing to you that the title "speech therapist" should be restricted to speech-language pathologists, as well as the title "speech-language pathologist." I do not know how useful all the rest of the material in this book will be, but you may find these sheets useful as you hear interest groups and consumers.

Mr Cordiano: If they are not getting the title "speech therapist," if the committee should decide to grant them that wish, what impact would that have in terms of the way the legislation flows now?

Ms Bohnen: If it were the will of the committee and the will of the government to make that amendment, there would simply be an amendment to the Audiology and Speech-Language Pathology Act adding the title "speech therapist," and then all the other boiler-plate language, abbreviations, translation, etc, would be added by way of an amendment. That is how it would be done.

Mr Cordiano: Would it be appropriate at this time to determine whether that is an appropriate thing to do?

The Chair: No. At this point in time we are being briefed by the ministry. Over the course of the hearings we will have an opportunity to hear from the groups that have an interest in the pieces of legislation, and through those discussions and debate. The time for tabling amendments from the different caucuses, as you know, comes—

Mr Cordiano: No, I was not referring to that. I was wondering whether I should pursue the question of what the ministry's intention would be on each of these items, what direction it is going to be willing to move in. That is what I wanted to establish at this point.

The Chair: You can certainly ask the question of the people who are here, but I believe that would be a more appropriate question for the minister.

Mr Cordiano: Okay, that is fine. I am not sure we see that in the draft amendments.

Ms Bohnen: No, you do not.

The Chair: Just to clarify, for Mr Cordiano and other members, what you see before you is—

Mr Cordiano: The basic ministry position.

The Chair: —what is in the legislation as it exists. Just to clarify this, what has been identified as another issue are those things which are not presently included in the legislation. Is that correct, Ms Bohnen?

Ms Bohnen: Yes. These are other issues identified by the groups, not by the Ministry of Health. It was just our

way of alerting you to what you will be hearing from them when they come in.

Mr Cordiano: Okay, that is fine. We can raise that as an issue.

The Chair: We can have that discussion at the appropriate time.

Ms Bohnen: The next one is "Chiropody and Podiatry." Since there were questions this morning about chiropodists and podiatrists, Ontario currently has a Chiropody Act, which registers both chiropodists and podiatrists. In practice, podiatrists provide limited bone surgery, as I mentioned, on the toes and on the forefoot. There is case law that they do so illegally because they are not authorized to do so by the Chiropody Act and it infringes on the scope of practice of medicine. You may recall that one of the parts of the review's mandate was to work out a certain number of interprofessional issues, which needed some resolution. Here we had a situation where we knew we had these podiatrists doing surgery that the courts were saying was illegal.

What should be done? The review consulted with the government of the day, of course, and the chiropodists and podiatrists. This analysis sets out the compromise that was achieved in full consultation with these groups whereby podiatrists would essentially be phased out of Ontario, but those podiatrists who are currently in practice and who were registered prior to the cutoff date that was selected would be permitted to perform legally the bone surgery which they have been performing illegally to date. The benefit to these podiatrists is clearly lawful. Their illegal practice is made lawful and they are recognized as legitimate providers of this service, but there are not going to be any more of them.

Remember that Ontario and Canada do not educate any podiatrists. We do not have any schools of podiatric medicine. These are people who are going down to the US, essentially, for education. The cutoff date was chosen to protect those Ontario residents who are currently in the schools of podiatric medicine in the US. We did not want these Ontario kids being educated to do something they were not going to be able to be registered for.

I suppose you could say the chiropodists are benefiting by the phase-out of podiatry. Chiropody all the more clearly will be the preferred way of providing foot care services in Ontario, but chiropodists will not be permitted to provide bone surgery.

The podiatrists will eventually be a dwindling group on the Ontario health care scene. The other thing they are not getting in the review's analysis is permission to use the title "doctor," which some of them have been using. They are not permitted to do so under the Chiropody Act.

1520

Mr Beer: One often sees "doctor of podiatry." Does that mean they cannot say that either?

Ms Bohnen: Their governing board does not think they should say that, but I think the main focus has been on policing use just of that short title, "doctor."

Mr Hope: I am just looking at "Scope of Practice" and "disability of the human foot." Do you mean to tell me a

nurse, if there were a disease or disability with an elderly person's foot, could not work on the foot?

Ms Bohnen: A nurse can assess a foot and provide nursing services and activities that are authorized controlled acts of nursing on the foot.

Mr Hope: But they could not grab the foot and start massaging it or doing anything to the foot?

Ms Bohnen: Massaging is not a controlled act. By all means, a nurse may massage.

Mr Hope: This is where a lot of the misinformation is happening, and some of the concerns that have been raised with me. England is pumping these people out right and left right now, I guess.

Ms Bohnen: Chiropodists?

Mr Hope: Yes. I have even had some come in my constituency office trying to get their certificates, and I have no control over that. But one of their arguments was that nursing staff are dealing with the disabled, walking in and grabbing an individual and starting to work on it. When you look at this, and I read "disability of the human foot," what does disability mean? I cannot move it, so it is disabled.

Ms Bohnen: But remember that the only things that are really being controlled are the controlled acts. When we get to these sheets about nursing, you will see that nurses have quite a long list of authorized controlled acts, but I certainly am aware of some turf disagreements, to use that phrase, between nursing and chiropody, as to which practitioner is the more appropriate provider of foot care services. That does go on, and I guess will go on.

The Chair: Perhaps you could give an example to Mr Hope about a procedure and care of the foot that anyone could do.

Mr Hope: No, that is fine. I understand what you said. You do not need to give me an example.

Ms Bohnen: Just one other issue: I think you will be hearing from chiropodists who feel they should be authorized to perform the diagnosis controlled act.

Turning next to "Chiropractic," chiropractors are certainly regulated, as you know, under the Drugless Practitioners Act. In the review's analysis, what chiropractors were getting was a limited form of diagnosis and lawful authority to use the title "doctor of chiropractic" and the short title "doctor." Many chiropractors certainly use the title "doctor" in Ontario today, but in fact they are not authorized by law to do so. There was a time within relatively recent history when the College of Physicians and Surgeons tried to prevent chiropractors from using that title, but this legislation will legally authorize them to use the title "doctor."

What are they not getting? The review said they are not getting the authority vis-à-vis laboratory tests. In fact, this legislation does not deal with laboratory tests at all; that is dealt with under the Laboratory and Specimen Collection Centre Licensing Act. Chiropractors, like some other professionals, would have liked this legislation to authorize them to order lab tests, but it just does not deal with that whole issue.

Finally, the review said their scope of practice does not include in it a general reference to the treatment of ill health.

"Changes in Bills:" One of the amendments which was distributed by the minister this morning would authorize chiropractors to manipulate the tailbone through the rectum. That was an additional controlled act they felt was appropriate for their profession, and no other provider group seemed to think it was a very contentious matter, so it seemed an appropriate way, to propose an amendment.

"Other issues:" That just signals the diagnosis issue we have heard some talk about. They are concerned about the ability to diagnose joint problems that have no connection to the spine or the nervous system.

Mr Beer: Do the terms "dysfunction" and "disorder" have a legal definition whereby one knows the difference between either of those two terms and a disease?

Ms Bohnen: They are not defined terms in this legislation. There are many taxonomies of health conditions used by various health professionals which do categorize various entities as either diseases, disorders or dysfunctions, or which seek to define them, but the review did not propose recommendations that would have defined them.

Mr Beer: Under "Other Issues," could we just say "not getting diagnosis of joints of extremities"? Is there a reason you have put in "diagnosis of dysfunctions or disorders of joints of extremities"? A number of people have asked, I am sure, many of us, "What is a 'disorder,' a dysfunction?" I want to be clear, because those terms are used frequently.

Ms Bohnen: The distinction is very significant to the diagnostic controlled act, which we will come to. As well, I think you should know that in the case of chiropractic, they are only permitted by the bill to diagnose dysfunctions or disorders, not diseases, but their ability to diagnose diseases has not been raised as an issue, to my knowledge.

Turning to "Dental Hygiene," Dental hygienists are regulated under the Health Disciplines Act by the Royal College of Dental Surgeons, but no dental hygienists sit as voting members of the council, nor do they have a scope of practice set out in the act, but the regulations, under the Health Disciplines Act, permit dental hygienists to perform the functions you see listed here under the supervision or direction of a dentist. What dental hygienists are getting first and foremost is their own college, which they sit on. They will be regulating themselves; they are not going to be regulated by dentists any more.

There are also reduced supervision requirements. It might suffice to say that the amount of independence and autonomy a dental hygienist should have is something that I think you will be hearing about from at least one provider group. In the review's analysis, they are getting their own governing body and somewhat reduced supervision requirements. However, they are not getting independent—that means independent of a dentist—periodontal scaling and root planing.

The bills have not changed very much, but there has been a semantic clarification of the reduced supervision requirements. Other than that, there is no change.

1530

Mr White: There are a couple of similar situations where a group is given a mandate to practise only under another profession. I believe people who are referred to as psychometrists can only practise under the supervision of a psychologist. Here is the same thing, the dental hygienist, yet that stands distinct from the issues in the criteria for self-regulation, where supposedly there is independent practice and risk of public harm because these people can practise independently.

Ms Bohnen: Dental hygienists do have an independent and autonomous scope of practice, by which I mean that under the bill there are functions they can perform completely independently of a dentist. The controlled acts, however, limit those things which are sufficiently hazardous to control them to begin with, and those acts are triggered by the order of a dentist.

To make this very concrete, a dental hygienist can only perform periodontal scaling and root planing when an order has been made by a dentist. However, they can assess the health of a mouth, participate in public health screening programs, provide teaching about dental hygiene, apply topical fluorides, do a number of things without the necessity of an order or direct supervision by a dentist.

The pattern of practice in Ontario has been, by and large, that dental hygienists only work in dentists' offices. However, one of the opportunities this legislation will be opening the door to is more effective use of dental hygienists in public health programs to provide more dental services more economically.

Mr White: Essentially, in some ways, the issue of independence of practice is a precedent, something which may occur in the future, given this act.

Ms Bohnen: Yes, I think that is correct. The actual degree of independence of many of these practitioners is something that may evolve over time.

Dental technologists: The review recommended that they continue to be regulated; that was certainly a benefit. By the way, I do not think dental technologists are as familiar to most consumers as many of the other groups are. They are the people who work in dental laboratories, designing and fabricating things like crowns, bridges, orthodontic devices and so forth. They do not have any direct patient contact. They fabricate these appliances on the prescription or order of a dentist and then sell the item to the dentist, who then dispenses it to the patient. That is what they do.

Under this legislation, they will continue to be a regulated profession. They have a change in title from "dental technician" to "dental technologist." That change from "technician" to "technologist" is viewed by most groups that have had that kind of terminology as preferable. "Technologist" has better connotations, from their viewpoint, than "technician." But what they were not getting, according to the review's recommendations, was the controlled act or

licensed act concerning the preparation or manufacture and design of these dental appliances. They have had a number of things to say about that, as have a number of dental groups.

Dentistry: The main thing the review felt they were getting from this legislation was statutory recognition of the role they play in treating disorders of what we call the "oral-facial complex." That is perhaps a more extensive term than the terminology used in the Health Disciplines Act, which refers to "human tooth, jaw or adjacent structure or tissue." What they are not getting out of this legislation or, one could say, what they are losing in this legislation, is complete control over dental hygienists and the prohibition on denture therapists or denturists from dispensing partial dentures. Right now in Ontario, a denture therapist may only lawfully dispense complete dentures, and the bills propose that denture therapists be permitted to dispense partials as well. Dentists have been opposed to that change.

Mrs Cunningham: I am just looking for information here. I am curious to know what would have made the ministry allow the partials. I say that with the question in mind that the one instance I had around that issue was a woman who came to me who had been diagnosed with a cancer and who at the same time had been given a partial denture that was not appropriate. It had been looked into because of complications. I am wondering if there were certain circumstances or what would have influenced the ministry, given her particular case, to allow that to happen. It is the only instance I have got. What is the background for the inclusion?

Mr Burrows: There was a similar issue back in the 1970s when denturists were first allowed to be recognized as a self-governing profession. We heard many of the same arguments then about total dentures as I think we have had with respect to partial dentures. We have heard nothing in the way of substantial evidence from any party, whether it be dentistry or some other profession, other than anecdotal information.

For example, when we have heard from dentists' representatives saying, "Here's some anecdotal information that there's harm out there," we have asked for comparative data. It is no secret that in every profession there are good performers and bad performers. We have asked them for comparative information in the same kind of experience with respect to dentistry, and that has not been forthcoming. It is one thing to produce a piece of anecdotal information about something that was botched by a nurse, a pharmacist, an optometrist, whatever, and it is quite something else to produce evidence about a substantial trend or data that would objectively prove there is a health hazard here of significance that goes beyond individual competence. To this date, we have heard nothing convincing along those lines.

Ms Haack: I had the opportunity to meet with a constituent recently who had a concern about a dentist and the fitting of a plate. He actually was very anxious to be able to visit his local denture therapist to get the impressions as well as to have the plates fabricated by the denture thera-

pist. From what I see here, the actual taking of the impression would still be in the hands of the dentist whereas the dispensing of the plate by the denture therapist would be allowed. Is that how it still reads?

Ms Bohnen: I would not say so. Something as specific and non-invasive as taking an impression is not a controlled act. What the denturists will be authorized to do is dispense partial removable as well as complete removable dentures, and all of the ancillary activities that are not otherwise controlled acts go along with that, so they would be able to take their own impressions for that.

Mr Beer: Could you elaborate on what would appear to be a request on the part of dentists to be exempt from quality assurance? Coming at that from one angle, it sounds rather bizarre.

Ms Bohnen: Unfortunately, I cannot. This part of the analysis was performed by the review somewhat before my time on it, so I would not even want to speculate. I did not want to change it as it was their work.

Mr Beer: All right. That helps. We can put that to the Ontario Dental Association when it is here.

Ms Bohnen: Just one other issue I think dentists will be speaking to is that one of the controlled acts is ordering or applying forms of energy that are hazardous. Those forms of energy will be prescribed by regulation under the RHPA. Dentistry would like to see that authority to order or apply such forms of energy in the Dentistry Act rather than dealt with by regulations under the RHPA. They will speak to that.

With regard to denturism, we have already spoken to the main very significant changes. They will be permitted to dispense partial dentures without the order or supervision of a dentist. They also are very pleased with the change of their title from "denture therapist" to "denturist." There is really no change in the bills of any significance.

1540

Dietetics: Dietitians are currently not regulated, so what are they getting? Statutory self-regulation. They are not getting any controlled or licensed acts, nor is nutritional counselling, for example, being restricted to dietitians. I think a couple of issues you may expect to hear from dietitians are that perhaps—I am not positive but they may be advocating that the title "nutritionist" as well as "dietitian" be restricted to their members. They may also be proposing that parenteral nutrition, which is for people who have health conditions making it impossible for them to eat and digest in the usual way—I am not sure how nutritional substances are provided. However they are provided, I think they are advocating that prescribing the composition of these nutritional supplements be restricted to dietitians. That was not the review's recommendation.

Mr Beer: Under this, there is the case—it has been going for a bit—where a young girl died and the parents were charged, but there was somebody—I forget whether he is called a herbalist—who had said she should eat certain kinds of leaves or something. There was a comment made during the case that they could accuse the parents but should something not have happened to this other individual who was making, I guess, a diagnosis and

prescribing a certain form of treatment. In terms of dietetics, what would this do to somebody who was recommending to a family that they should follow some set of procedures with the nutrition of their child? Because of the 13 controlled acts, does this provide that there would be a way of legally moving against someone—I do not mean necessarily in this case—who was doing that kind of thing?

Ms Bohnen: Nutritional counselling or dietary advice is not restricted in any way. If it is coupled with a diagnosis, then presumably it would be possible to prosecute the individual for performing that controlled act, which, I guess, is the first time we have seen the other side of the issue. So far we have seen the issue from the viewpoint of not impeding practitioners. You have raised it really from the other viewpoint: How can the public be protected from reckless or poorly informed practitioners? But on its own, not coupled with one of the other controlled acts, which, apart from diagnosis, are all pretty invasive, there is nothing in the bill that would prevent the person from doing so.

Mr Beer: This would just bring us back to, when we get to the important meaning of "diagnosis" and "assessment," if you could not demonstrate that somehow there has been a diagnosis, then presumably there are still a number of things that people generally out there can recommend and I suppose, if parents are not thinking enough and follow it, this is not going to control everything.

Ms Bohnen: That is right. It is not going to control everything.

Mr Hope: Just a couple of quick questions. What is this going to do with dietitians about these pop-up shops that are around on this losing-weight category? Is it going to restrict the amount of pop-up shops we have dealing with diets?

Ms Bohnen: No, it will help the public to recognize who is a registered dietitian and a member of the college with prescribed qualifications, quality assurance requirements and so forth. It will help the public recognize that person from someone who does not have those qualifications, but it will not stop what you refer to as pop-up shops.

Mr Hope: Yes. Well, they are popping up all over the place.

Interjection: It is not a form of food.

Mr Hope: No. The other is that I sometimes wonder why they would not be together, nutrition and dieting. Dieting is not stopping eating; dieting is eating the proper foods which are nutrients to your body. Why are they not together?

Ms Bohnen: In the case of the parenteral nutrition, it is my understanding that the review, first of all, believed that these are people who are under the care of a physician and who are receiving all kinds of very sophisticated health care and that the identification of the correct supplement is sufficiently controlled in that way. Second, it is my understanding that these nutritional compounds are basically pre-formulated items which you pull off a shelf. It is not like cooking up a formula from scratch; it is more like a

cake mix than baking something from scratch. So there was really no need. The public did not need to be protected in this way.

Mr Hope: Say, for instance, that I go and get my cholesterol checked and I find out my cholesterol level is gone—which is quite common around here, I guess, with the food—and I need to talk to somebody to control my cholesterol level. Do I go see a dietitian or a nutritionist? Because this is where the diagnosis part comes into play. You know, I am diagnosing myself as high cholesterol, or I get it checked and I have a high cholesterol—

Ms Bohnen: It would be difficult for you to diagnose yourself with high cholesterol because, remember, only physicians and a few other groups not relevant to this discussion can order the lab tests to determine that you have high cholesterol anyway. If you want to find out if you have high cholesterol through a blood test, you are going to have to go to your physician. Let's say your physician has told you you have this. I would not call it a diagnosis, but I would say if he or she tells you, "You have high cholesterol," either the physician will provide you with the nutritional counselling or will suggest to you that you go to someone else for it. Now, you may want to know, "Should I go to a dietitian or a non-dietitian nutritional counsellor?" You will have to decide that for yourself. But hopefully with the kind of public education that was talked about a little bit this morning—the public is going to have to be educated so that you can make a wise choice between these two practitioners.

Mr Hope: That is what I am looking for, protection of the public, and this is why I raise these questions. How many people really take the time, being pushed in and out of a doctor's office, to ask those questions? That is why it is important. We talk about two categories. We are still going to have two categories out there. Which one is the credible one for the general public? That is why I raised the question.

Ms Bohnen: Certainly the member of the regulated profession will have certain additional credibility, one would presume. But you can imagine that if there was a proposal to prohibit people other than the dietitians from providing nutritional counselling, you would end up, in rural parts of Ontario in particular, with nobody to go to for nutritional counselling.

Mrs Cunningham: I think one of the key questions, unfortunately or fortunately, would be, who pays? How would you respond to that?

Ms Bohnen: In a variety of settings members of these professions are paid because they are in salaried positions in hospital clinics. Apart from that, for those in private practice some kinds of extended health insurance cover some kinds of practitioners and not others. After that, it is however consumers decide to spend their own dollars.

Massage therapy: pretty short here. What are they getting? Continued self-regulation. They are currently regulated under the Drugless Practitioners Act. There are no controlled acts restricting massage to this profession, nor are they being authorized to perform spinal manipulation,

such as is performed by chiropractors and physicians and physios, and there are no significant changes in the bills.

1550

Medical laboratory technology: They are not currently regulated in terms of having their own college. However, the Laboratory and Specimen Collection Centre Licensing Act does in fact regulate to some extent who is employed in licensed laboratories as technologists, technicians and so on. But for the first time they will have their own college and will be self-regulating. However, they are not getting the performance of laboratory tests as a controlled act. That will not be a controlled act.

There are some changes in the bills which are outlined on page 2 of that summary, and one of those included the example the minister gave this morning. They have to be able to collect blood. That is what they do when you go for a blood test. In all probability the blood is being drawn by a lab technologist or someone who is supervised by a lab technologist. As well, there are some non-contentious amendments to their scope of practice.

Medicine: The analysis for medicine which appears on page 3 differentiates between the physicians of the College of Physicians and Surgeons, or the CPSO, and the Ontario Medical Association, because here those two organizations have had very different responses to the proposals.

Fundamentally, and I guess most important, the College of Physicians and Surgeons has been opposed to the new regulatory model. The college believes that the public would be better served if the exclusive scope of practice of medicine were preserved. The OMA has not taken that position and does not have any difficulty with the new regulatory model.

As you might expect, they have quite different responses to some of the proposals. For example, the college would like to see provisions which would make it easier to discipline physicians, and the OMA, needless to say, likes provisions which safeguard members' procedural rights. To some extent their mandates are just in direct conflict and that accounts for the different positions they have taken on some issues.

Just by the way, the regulatory authority over osteopaths is being transferred to the College of Physicians and Surgeons. Currently osteopaths are, theoretically anyway, regulated by their own governing body under the Drugless Practitioners Act. In fact, we have a very small number of practising osteopaths, all of whom are getting on in years and, judging from information made available to us from OHIP, are not in very active practice, many of them. The review concluded that while osteopathy could continue to be a regulated profession, it was not feasible to regulate them as a separate distinct profession and therefore they should be on a special register administered by the College of Physicians and Surgeons.

There are some changes in the bills. For example, the bill recognizes that physicians do not in fact supervise pharmacies, that physicians do not in fact fit and dispense dental prostheses. Conceptually, the way the health care system has traditionally operated is in imagining that physicians do everything, that every other provider group just does a little bit but physicians do everything. For the first

time, I think this legislation recognizes that physicians do not do everything.

Finally, in terms of other issues, I think you will be hearing from the College of Physicians and Surgeons that it feels some additional provisions should be added to the procedural code dealing with continuing confidence. Also, later on there will be some recommendations tabled dealing with sexual abuse of patients.

Mr White: Just one small question—really slightly outside of the scope of this afternoon's endeavour—on the recommendations of the task force on the sexual abuse of patients, which came up fairly recently: My understanding is that a large number of those physician-patient relationships were of a supportive, counselling nature. I am wondering, with the release of that task force, whether that information could spur any kind of change in terms of regulation, the tremendous issue around harm, obviously. I gather that is controversial. You can set it aside for now.

Ms Bohnen: Right. The report you have referred to was a preliminary report, and after it was released there was much feedback provided to the task force. It is my understanding that the task force and the college are scheduled somewhat towards the end of these hearings, and I think you will hear proposals for additional amendments to the bills. The minister has already proposed in the package that was distributed today a couple of amendments that respond to some concerns, such as permitting a complainant to remain in the room during a hearing that is otherwise closed to the public.

The Chair: Any further questions? Please continue.

Ms Bohnen: Midwifery is, as you know, obtaining recognition, legislative authority that midwives are appropriate health care providers for Ontario, as well as statutory self-regulation. Most of the other groups that are not currently self-regulating have nevertheless been recognized as players in Ontario's official health care system. That has not been the case for midwives. So they are getting statutory recognition as well as self-regulation.

The recommendations the review made in terms of their scope of practice and controlled acts arose largely from the recommendations of the Task Force on the Implementation of Midwifery in Ontario. The small changes to the bill that you see here I think are items that resulted from consideration of the issues since that task force made its report, and these have benefited from the deliberations of the interim regulatory council on midwifery, which has been in operation I guess going on two years now. I do not believe that these are contentious changes to their bill.

Moving on to nursing, there are a number of nursing organizations which have different views on this legislation. In the review's analysis, what nursing was getting from the bill was, first of all, for the first time, at least a descriptive definition of the scope of practice of nursing. Even though we have had legislation in Ontario that regulates nursing for I guess the better part of the century, we have never had a statutory description of what it is that nurses do.

Second, the title "nurse" is being protected for the first time. Although the titles "registered nurse" and "registered

nursing assistant" are currently protected, the bare title "nurse" has not been protected in Ontario.

Nurses have a fairly long list of controlled acts, although most of those acts are triggered by the order of another practitioner, a point I will come back to in a minute.

They are also getting a title change from "registered nursing assistant" to "registered practical nurse."

What are they not getting? The registered nursing assistant, to become registered practical nurses, are not getting a separate college. They will continue to be clustered with registered nurses under the College of Nurses.

Nurses are not being authorized to perform diagnosis, nor is the practice of midwifery being restricted to nurses, which is something at least certain nursing organizations wanted.

Changes in the bills: One of the key changes will be the ability given to the College of Nurses to, by regulation, prescribe which controlled acts may be ordered by a nurse. Usually, the order must be made by a practitioner who functions at a higher level. For example, a dentist makes an order that may be carried out by a dental hygienist. Much of the time, it is a physician who makes an order which may be carried out by a nurse, but this legislation will enable the College of Nurses to specify what kinds of controlled acts may in fact be authorized by a nurse and then carried out by a nurse.

Some other issues which you see flagged are not very complicated. Some groups feel that the exception for the titles "dental nursing" and "Christian Science nurse" should be eliminated.

1600

Mr Hope: This is where some of the problems dealing with emergency rooms come up with the controlled acts.

Ms Bohnen: Let's come back to what it means, then, to have to have an order, because I think what some groups, such as some nursing groups, are saying is: "Look, we have to be able to respond to such and such situation. We can't hang around waiting for a physician to examine a patient and make an order."

Mr Hope: Before you go on, are you talking about standing orders in emergency rooms or what?

Ms Bohnen: That was one of the things I was going to speak to you about.

Mr Hope: Okay. When you said orders, I just wanted to find out.

Ms Bohnen: We know that the way emergency rooms, intensive care units, the way hospitals in general operate, is that there are many standing orders or routines so that the nurse knows that in such and such situation she has the authority to perform a particular procedure so the nurse does not have to wait for the patient to be examined by a physician and for a patient-specific order to be made.

The same thing applies, by the way, for dental hygienists, who know that, given a certain fact situation, she may go on to scale the patient's teeth. She does not always have to wait for the dentist to examine the patient first. Does that respond to the concern you were raising?

Mr Hope: They talk about a heart attack patient coming in and using their normal skills and applying stuff right away and attending to the patient, to care for the patient. Then under the controlled acts, and hearing what you just told me and reading the controlled acts, I think it is a matter of public understanding of what is taking place here. There is not a circle of communication. The communication seems to be bouncing one way and not back the other way.

Ms Bohnen: I think you will be hearing from several nursing groups. I think the College of Nurses and the Registered Nurses' Association of Ontario understand the nurses will continue to practise more or less as they practise now. They do not wait for a physician order before they provide care within their expertise. I have no doubt that you are hearing from other groups who are saying otherwise, but I can tell that these bills do not require a patient-specific order in every case. What they require, though, are some guidelines, and remember, these may either be standing orders, patient-specific orders or regulations made by the College of Nurses, which say that, "In such-and-such situation, this is how you are supposed to carry on." Remember as well that there is an exception from the controlled acts anyway for first aid and emergency care.

Mr Hope: Okay, similarly, using a child with asthma and a heart attack patient coming in, when they looked under the health professions regulations, they said they are not able to do anything because they have not had an order from a doctor. Looking at rural Ontario, we do not have doctors sitting right in the hospitals 24 hours a day. We are lucky if we can get them in there eight hours a day. They depend on the beeper or depend on phone services or something like this in order to get these orders, and this is where a lot of concerns from rural areas come from. They went through all this schooling, have had their degree and 20 years of service or whatever, and they are feeling that their ability to move and ability to service the public are being taken away with this regulation.

That is why I keep referring back to these pieces of paper that are in front of me. What is written here, what you are telling me and what they are telling me—I was in the middle of about 150 nurses, so it was not a friendly place to be at, especially being on the government side. But I listen to the concerns they have, and this is where I am trying to make sure that the understanding—and this is why I brought up earlier about the transition period.

I understand standing orders. Are we losing sight of the standing orders that are currently—

Ms Bohnen: No, we are not.

Mr Hope: Or are the standing orders always going to be a part of it? They could still continue to practise what they have always been doing, treating the patient as soon as he is diagnosed. "Doc, here I am diagnosed, assessed as a heart attack patient," and bang, you can treat him.

Ms Bohnen: Absolutely. They can carry on.

Mr Hope: Okay.

Ms Bohnen: Occupational therapy: Again, they are getting statutory self-regulation but not any controlled act.

Not much change in the bills other than what I have mentioned before about title protection. Another issue for them is the ability to diagnose, which they are not getting in these bills.

The next profession, ophthalmic dispensing: What are they getting? First of all, a change in title from "ophthalmic dispenser" to "optician." Eye care is a complicated area because many members of the public, and some of us, have trouble distinguishing between ophthalmologists, optometrists and opticians. Opticians are the people who fit and dispense glasses and contact lenses. Optometrists are the people who assess vision and also dispense eye glasses and contact lenses. Ophthalmologists are physicians who have specialized in eyes. So we have eye doctors, optometrists and opticians. They will continue to be regulated and they will have a controlled act dealing with dispensing of eye glasses, contact lenses and so forth.

There is no significant change in the bill. The main issue I think you will be hearing about comes from the fact that the bills and the review do not define all of the elements of dispensing eye glasses. There is, in contention, the issue of whether an optician should have to perform all or nearly all of the various functions that go into dispensing eye glasses or whether some of those functions can be performed by people who are not registered opticians, provided the final product is okayed by an optician. I think you will be hearing from an industry group as well as from the opticians about this issue.

Optometrists are currently regulated under the Health Disciplines Act. In the review's analysis, what they were getting was essentially the status quo, including the authority to make a limited form of diagnosis. In fact, I think what you will be hearing from them is that they are quite dissatisfied with their scope of practice as recommended by the review and with the limitations on their ability to diagnose. In addition, they would like to see specific authority to order and prescribe forms of energy and to perform allergy tests and procedures in the cornea. But these are, to them, less important issues than the issue of the breadth of their scope of practice and the breadth of their ability to diagnose.

Ms Haeck: I have also, as many of us have, met with various specialties in my constituency and I have met with some optometrists in my riding. What they portrayed for me as a scenario was that if I went to them and needed to be assessed for glasses, but during that, they have a whole range of devices to check for glaucoma and other things, they in fact could not tell me that particular fact, that I might need to be treated for glaucoma. They would have to send me to an ophthalmologist in order to have that diagnosis delivered to me.

Looking at this, you are under the controlled acts in a very specific fashion. I would judge that possibly that is not totally so, but I would like you to expand on that.

Ms Bohnen: Optometrists play a very important role in screening people for eye diseases like glaucoma for which medical treatment is necessary. Currently in Ontario, under the Health Disciplines Act, optometrists cannot use drugs for therapeutic purposes, they cannot do eye

surgery and so forth. So what they do is provide this very valuable screening and then refer the patient to a physician, because you have to be treated by a physician for glaucoma and other eye diseases. That will not change under these bills, but what the review concluded was that an assessment and screening function, optometrists believe, is a diagnostic function and the optometrists would like the statute to recognize that they do diagnose glaucoma. The review said: "No, you don't diagnose glaucoma. You recognize the signs of glaucoma and refer the patient to a physician, which is the only place the patient can get the necessary treatment."

1610

Ms Haeck: What the two optometrists sitting across the desk from me indicated was that they could not tell the patient that he had glaucoma. They would have to say: "You have a problem but I can't tell you what it is. I am going to have to send you to an ophthalmologist." Somewhere six months hence, you have this appointment with the ophthalmologist, and you are living under this cloud for six months, not knowing what particular problem you may have and obviously not receiving treatment.

Ms Bohnen: One of the elements of the controlled act of diagnosis, which we will come to shortly, does refer to it being a statement of a very conclusive nature: "Look, I have measured the pressure in your eye"—that is how they do it; it is a device that measures eye pressure—"and the pressure is up. That is a sign of glaucoma. You need to go to a physician." If the wait is six months, the patient has a problem, not because he has to wait on tenterhooks waiting for the diagnosis, but because he is going to have to go untreated for six months. He cannot get treatment from an optometrist for glaucoma.

I think it comes down to the difficult issue that we have been talking about already today: What is the extent of this controlled act and how in practice, using some common sense here, is it really going to play out?

Mr Beer: Just to underline what Ms Haeck has put forward in her questions, because I think we have already had visits over the last few weeks from optometrists and we will want to talk to them about this when they come: There really is a concern around this assessment-diagnostic. There clearly is also a problem in the relationship with ophthalmologists and to what extent the ophthalmologists are dictating the optometrists' scope of practice. I just would want at this point, for the record, to put that out, because I think as a committee we are going to have to get some better sense of just how those two groups are going to be able to work and live in some harmony with this.

This is why I come back to communicating what is meant by being able to assess, because the glaucoma example is the one that we were all provided with. I suppose my reaction to that is, what would you expect in a reasonable situation? An optometrist would say, "Look, I think what you've got here is glaucoma, for which you need to go and see a certain kind of person." But there seem to be problems—and it may be more than just optometrists—around, "Have I made an assessment or have I made a

diagnosis?" I appreciate there is perhaps some meaning for that, but this is one that we have all, I suspect, received from the optometrists. We are going to have to get a clearer sense on that, because clearly as a group, they feel they have lost something in this. I understand you are saying no, they have not, but that is what they are telling us.

Ms Bohnen: I know.

Medical radiation technology: They are currently regulated under the Radiological Technicians Act, so they too are getting a title change from "technician" to "technologist."

The Chair: I do not think we have that in the book. Pharmacy is next.

Mr Bohnen: Oh, I am sorry. I do not know how I did that. I flipped ahead. I am sorry.

The Chair: It is further along.

Ms Bohnen: We will flip back to pharmacy, okay?

Pharmacists of course are regulated under the Health Disciplines Act. There is a change to their scope of practice. It emphasizes the counselling component of pharmacy. The review recommended that existing restrictions on the ownership of shares in corporations that operate a pharmacy be removed. That was changed in the bills introduced by the previous government and this government, and so those restrictions on the ownership of shares have been restored. Other than that, there is no significant change.

Physiotherapy, currently regulated under the Drugless Practitioners Act: Under the regulations under that act which regulate physiotherapists, with a few exceptions, physiotherapists are not permitted to treat patients except on a prescription from a physician, so they do not have primary contact with patients; you always have to go to a physician first. That restriction has been eliminated from the bill, so that henceforth patients would be able to go directly to a physiotherapist. They would not have to go to a physician first. They are not getting authority, in the bill, to perform diagnosis.

There is a title issue here. The title recommended for protection by the review was "physiotherapist." The profession would like to see the title "physical therapist" protected as well, and I believe they may be advocating some additional invasive procedures. Included in the package of amendments the minister brought with her today was one that would permit them to perform tracheal suctioning, which is something physiotherapists currently do.

Ms Haack: Is the performing of that particular act, tracheal suctioning, something that initially may have been ordered by a physician and is just a continuation of that, or is this something they are able to assess on their own?

Ms Bohnen: Our advice was that this was something they were able to assess on their own. I think it is provided both in hospitals and in community settings with disabled people. With the proposal you saw they would do it on their own. There would not necessarily have been a physician's order to begin with, although we are talking about sick people here or people who were once sick, so there will have been a physician involved in any case.

Psychology: Psychologists are currently regulated under the Psychologists Registration Act. Again, like nursing, it is an act that only provides the benefit of title protection to members of the profession. No service is currently restricted to psychologists in Ontario.

Under the bills, they would be specifically authorized to use the title "doctor." They have been authorized to perform the controlled act of diagnosis within the psychological arena, but they have not been given an authorized act to perform psychological testing, for example. The performance of psychological testing is widely done by psychometrists. A diagnosis based on the outcome of that testing would be restricted to psychologists, however.

As I understand it, the main issue for psychologists is the scope of the title protection for members of that profession, including protection of the words "psychology," "psychological" as well as "psychologist."

Medical radiation technologist, which I had skipped to before: I do not think there is anything of too contentious a nature here. In the amendments the minister brought with her today, she has proposed that their scope of practice be amended to permit the minister to add the diagnostic use of other forms of energy. For example, the review did not recommend that regulation of ultrasound practitioners be included in this package. If at some point in the future it is decided that ultrasound operators or some other kind of technologist who utilizes the form of energy should be regulated, it might be that they could be clustered with these radiation technologists.

Finally, the respiratory therapists, who are not currently regulated, are getting their own college. There is no change to the bills from what was recommended for them by the Health Professions Legislation Review. Now we have finished with this.

The Chair: If I may interrupt, the time is now 20 minutes past 4. The next sections you are getting into, which deal with the issues you have identified under section L, could take some time. If it is the wish of the committee, we can decide how late we want to go today and then schedule tomorrow. The way our schedule is looking, we can have our lunch break from 11:30 till 1:30 and then have the ministry continue the presentation from 1:30 till 2:30, when the public is going to be able to continue presentations.

Mr Beer: I think these are really important and I am already 20 minutes late for something else. If it is possible to do this at a time that would be more acceptable for everyone, I think we really do want to get our teeth into this section. It may not be the time that is suggested, but I would certainly appreciate another time this week if we could.

Ms Bohnen: I apologize for running so late with my material.

Mr Beer: No, not at all; it has been very helpful. I just think dealing with these at the end of the day—if we can have it when we are fresh—

The Chair: There will be opportunities over the course of the next few weeks when we find adjustments in the schedule, or if we want to invite the ministry to get into

some of these issues following discussions with the deputants, if there have been cancellations, when we can try to set aside some time for those discussions. That is something the whips might want to discuss. We can attempt to do that.

Shall we adjourn for today, reconvene tomorrow at 10 o'clock and ask the ministry to continue from 1:30 to 2:30, starting at section L? Is that agreed? Any discussion? No? We stand adjourned until 10 o'clock tomorrow morning. Thank you all.

The committee adjourned at 1623.

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Professions Act, 1991
and companion legislation

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Première session, 35^e législature

Journal des débats (Hansard)

Le mercredi 7 août 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
Greffier : Lynn Mellor

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 7 August 1991

The committee met at 1003 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉE ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi concernant la réglementation des professions de la santé et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: Good morning. I would like to welcome everyone to the standing committee on social development. We are examining a packet of bills known as the Regulated Health Professions Act. There is someone here from each of the caucuses, so we have a quorum and we will begin.

ONTARIO NURSES' ASSOCIATION

The Chair: Good morning. The rules of the committee are that you have been granted 20 minutes for your presentation. We would ask that you leave some time for questions from the committee members. We welcome you and ask you to begin your presentation now.

Ms Davidson: Good morning, Mrs Caplan and members of the standing committee on social development. My name is Eileen Davidson, and I am the president of the Ontario Nurses' Association. With me today are Heather Dolan, our chief operating officer; Lesley Bell, assistant director of government relations; Arlene Babad, our nursing practice officer; and Carol Helmstadter, our research officer.

I am pleased to be here to address the concerns that the practising staff nurses in this province have concerning these three pieces of legislation: the Regulated Health Professions Act, the Nursing Act and the Midwifery Act.

First, I would like to acknowledge and thank the various Health ministers and their staff for the opportunities that have been provided for nurses and all other professions to have input into this very lengthy process.

As I am sure you know, the Ontario Nurses' Association is a trade union and represents 55,000 staff nurses who form the backbone of this province's health care system. These nurses work in hospitals, nursing homes, homes for the aged, community health and in private industry.

At the outset, I must say that as nurses we were disappointed with the proposed legislation, as we had hoped and expected that the role of nurses would be expanded. Instead, we believe this legislation neglects to recognize the nurse as an autonomous member of the health care team.

The legislation puts the practising nurse in a completely untenable position and will result in even more nurses leaving the profession. We support fully the intent of this legislation to protect the public from unqualified, incompetent and unfit health care providers. However, in order to do that, the legislation must also enable nurses to practise safely and efficiently.

In our written brief we have discussed in detail our concerns, but for this presentation I have narrowed our focus to the four main issues of concern to staff nurses.

Number one, and of prime importance, is that we do not believe that licensing and controlling certain hazardous acts will protect the public. On the contrary, we believe this is not in the best interest of the public. Instead, we recommend that all professions which are to be regulated should be licensed according to their scope of practice. Without licensing, we believe that there will be a proliferation of health care workers, care will be further fragmented and the public, instead of being protected, will be left in the hands of a confusing array of both qualified and unqualified health care workers.

Nursing is being taken away from nurses and delegated to others based on the budget, not on proper patient assessment or care. The government's effort to introduce competition into the health care field is an understandable effort to reduce costs, but do we want to see competition introduced at the expense of losing quality care? The public has come to expect the best, not the cheapest, and the ONA believes this is a reasonable expectation and we will continue to try to meet it.

Currently in Canada, six provinces have adopted an exclusive licensing mechanism for the practice of nursing. That means that nurses have a right to practise within a defined scope of practice.

I refer you to our written submission, specifically reference 1, where it states: "It has been suggested that in provinces where the legislation provides only a registration mechanism, and not an exclusive right to practise nursing, the public is not sufficiently protected." The present system and the proposed legislation protects the title but does not protect nurses with the exclusive right to practise nursing. In our opinion, it therefore permits unqualified nurses to practise and is inadequate to protect the public from unsafe and unethical care.

We agree with the statement from J. J. Morris's book *Canadian Nurses and the Law*. Mr Morris says, "It is essential that the College of Nurses have the right to license those who practise nursing within the defined scope of practice and that these licensees have the exclusive right to practise within that defined scope." His complete article is attached to our written submission, reference 1.

The second issue I would like to address is the critical need to include within the scope of nursing practice

registered nurses who are administrators, researchers and educators. The teaching of nurses, the decision of nurse administrators and the orders which they give to their employee nurses directly impact on nursing care, often to the detriment of the patient. For example, it is not uncommon to work seriously short-staffed, which is potentially dangerous to the members of the public who are our patients.

In the past, the College of Nurses of Ontario has lost appeals to the courts because the courts found that the present Health Disciplines Act only applies to practitioners who give direct, hands-on care. That is us, the staff nurses. Under the proposed legislation we can see nothing that would change this situation.

1010

The ONA believes it is crucial that nurse educators, administrators and researchers become accountable to their governing body in order to protect the public. It is worth noting that the Canadian Nurses Association has already recognized this need by establishing its own standards for these nurses, and this position has the support of the College of Nurses of Ontario.

The third issue is the imperative need for the proposed legislation to formally recognize that many regulated professions will have dual accountability, as a professional and an employee. For staff nurses, this dual accountability means they are responsible to both the College of Nurses and their employer.

The Ontario Nurses' Association has much insight into this unique problem, as we are the only regulated profession right now in this unenviable position of dual accountability. As Florence Nightingale wrote, "Nurses must work under conditions where it is possible for them to deliver good care or they will become totally demoralized."

In our experience, with the basic conflicts between these two roles, if they are not worked out, nurses will continue to be frustrated in their efforts to deliver professional nursing care. This jeopardy situation reduces nurses to feeling compromised and insecure, and this is probably the single most important reason why qualified nurses leave nursing.

The fourth issue I wish to address is the proposed establishment of an independent college of midwives. It is our position that midwives should be nurses first, that midwifery should be regulated under and by the existing College of Nurses. While we support the right of women to choose how childbirth is conducted, the management of labour and normal delivery is a specialty of nursing, just as obstetrics is a specialty of medicine.

In closing, I would like to urge the committee members to review in depth the concerns of the Ontario staff nurses. We believe that all professions should be licensed with a defined scope of practice; that registered nurses who are administrators, educators and researchers should be included in the scope of practice and become accountable in order to protect the public; and that midwives should be nurses first. We believe our suggestions would ensure that both the public and the profession to be regulated would not only be treated fairly, but also the public would gain maximum protection.

Due to the late receipt of the government amendments, we reserve the right to forward a further written submission indicating any modifications to our current position. We would be pleased to answer any questions.

The Chair: For the record, I would like to point out that written submissions are welcome at any time through the course of these hearings, and all groups should feel welcome to communicate in writing with the committee.

Mr Owens: Ms Davidson, with respect to your comments on the necessity to have a scope of practice, with the specialization of medicine how do you see the role of the nurse being compromised? I sense that is what you are alluding to, that certain things that nurses have been doing up to this point they will no longer be able to do, or that in a situation where a practitioner, such as a respiratory therapist, is not available, or a physician, that the nurse, knowing the patient requires some medication or some form of treatment, will be torn between giving the treatment or trying to find that type of specialist. Is that what I am hearing and is that your interpretation of the bill? Is that what it will do to your profession?

Ms Bell: I will take a stab at that. I think you have brought in a number of things in your question. I will try to answer as best I can.

There are comments that nurses now function without written orders, and the legislation is not going to change that. Our comment would be that they are in fact functioning quasi-illegally in that instance now. Our hope of the legislation was that it was going to pretty well define what our role was and give us the independence to practice within that defined scope.

Our problem with not having a defined scope of practice means we have to look for orders. We have heard all kinds of comments that there are standing orders that are applicable, or policies and procedures within the institution that give us coverage. Those are only as good as the paper; they are written on, and if they are not duly signed by an authorized attending physician, then we have basically stepped outside our role and gone ahead and in fact practised without proper coverage. Our concern is that this may not change how all nurses function tomorrow, but it really puts us still in jeopardy, and that was the issue we were trying to alleviate with new legislation.

Ms Davidson: I would like to expand, too, on the quasi-illegal. This is really my baby. You have no idea how many times a nurse practises because the patient expects it, the public expects it, the administration expects it and the doctors expect it. You go ahead and you do it because it is the right thing to do at the time and then you wait for the doctor to write the order to cover you. What if that doctor decides he is not going to write that order? Now we are up against a \$25,000 fine. Once, only once, will I do what I think is right and that will be it.

Ms Babad: The other comment regarding a defined scope of practice and only allowing the appropriate health care provider to perform that is the concern when you have, for instance, many unregulated health facilities where people who are not qualified are doing certain activities. We are clearly familiar with the rest homes and the

problems there. By restricting the practice of nursing to qualified nurses, it helps resolve that problem.

Mr Beer: Could you elaborate a bit on your concerns with respect to midwifery? As you are aware, this is a subject that over the last—certainly since I was first elected in 1987, I have had a number of people in talking about that issue, the need for an independent college and in particular the arguments around the European and the British approach to it.

I would like to get a better sense of—I realize there is more in here as well—fundamentally why there should not be a college and why one, in your judgement, ought to be a nurse before being able to be a midwife, when in other jurisdictions there is certainly an historical tradition of people performing that role.

Ms Babad: There is a number of reasons we have taken that position. Certainly one is that we believe the essence of that type of practice starts out from a broad generalist base. It is fine while midwifery is only dealing with the norm, but you do not always know what is going to occur, and something abnormal could be occurring which a person who does not have that broad generalist knowledge first could miss. In other words, you are assuming that nothing is going to be wrong, and there is no way one can assume that in the world we live in. So many practitioners, if they do not have that broad generalist knowledge, could miss other things that do not necessarily touch on the aspect of birth.

The other reason, of course, is that in many remote areas it would be of benefit if the person was also a nurse and qualified as a nurse-midwife to deal not only with midwifery issues but those other nursing issues. If the person is going to be regulated under two colleges, because they need a nurse and a midwife, we can certainly see confusion resulting. We have addressed other concerns as well in our submission.

Ms Davidson: Presently, among the staff nurses we have several nurses who work in labour and delivery who are midwives from other countries and have been educated elsewhere and are practising as nurses now. All of us who have had any experience in labour and delivery have worked with nurse-midwives who are practicing as nurses with this extra education. It is really nice to have them around when you need them.

1020

Mr Beer: Can I ask one quick follow-up? Has your association or have you had any kind of relationship with the new interim council that exists or discussions about its program or how it is operating?

Ms Davidson: Yes. We have had ongoing representation on the interim regulatory council. Our representative is Ina Casey. She is a labour and delivery nurse and has been representing us right from the beginning.

Mr Hope: During your presentation, and I may have misunderstood you, you said something like, "Standing orders are not as good as the paper they are written on."

Ms Bell: That was my response to a question, yes.

Mr Hope: I raise this question because I know in emergency rooms and other areas in the institutional settings, you have standing orders. When you commented that they are not as good as the paper they are written on, then I am starting to have questions. Why are they not?

Ms Bell: Standing orders have to be authorized by a physician once the physician becomes in attendance. The problem arises that if a physician questions what your decision was in an emergency room situation, the fact that you decided this patient was suffering from X and instituted protocol X to match it, and he determines that something went wrong and maybe he does not agree it was right, then you have actually worked without an order there.

In every hospital, certainly in my history of practice, standing orders come into vogue and out of vogue. For a long time, we had standing orders for every patient that was admitted to a specific floor, with a specific diagnosis, for surgery the next day. The problem was that then there were questions by the public: "How can you do all this when the doctor hasn't seen me and I've determined that there is something else wrong with me in the interim?" Then it is left to the nurse to say: "Okay, we won't institute any of these orders. We'll wait until the physician comes in." The physician comes in and says: "Why weren't these orders carried out? You know this." So all of a sudden, the hospital will decide: "We're not using standing orders any more. We're going to go to the situation where every order has to be written." Then you get to the problem, "We'll take verbal orders," and it just goes back and forth.

Our concern is that the nurse is left holding the bag 99% of the time if there is a dispute with regard to how those standing orders were implemented.

Mr J. Wilson: As I scan through your brief, you have a lot of concerns about almost every section. Is there anything you like in this proposed legislation?

Ms Bell: Sure. We like the fact that it is being looked at.

Ms Davidson: We like the fact that we have had input.

Mr J. Wilson: Have you had much success with the ministry with your concerns over the years? This legislation has been going on for a decade.

Ms Dolan: The best example of that is that we were here with pay equity and we are now in the courts with pay equity to prove what we said before a similar committee about pay equity. So if we have to go the court route again, we will be in court again. I do not know what we have to do to prove to people that nurses who are working at the bedside are seriously concerned about this legislation.

Ms Bell: Our concerns are certainly different from the other nursing groups that you will probably have present to you. There have been references made that both the college and the Registered Nurses' Association of Ontario are very supportive and understand the legislation. They understand the way it has been presented to them and how it applies to them. Our concern is that as practising nurses, it applies differently to us. We are the ones who are there who are left in jeopardy. We are the ones the Health Disciplines

Board comes down on and so on and so forth. Our concerns have not been addressed adequately, and that is why you see a brief of this size.

Ms Babad: In addition, this piece of legislation was modelled after the Health Disciplines Act. As practising nurses we are very familiar with the problems that have occurred because of that piece of legislation, so we would have liked to see some changes made to this beyond that.

Ms Bell: I just want to throw in with regard to this. For example, you have heard from other groups or you will be hearing from other groups that there is a question as to the accountability of educators, researchers and administrators. You will be told that they are accountable under the legislation. They are accountable for incapacity and professional misconduct. Our problem is that they are the ones who assign our workload. We are the ones who have to carry out what they tell us to do, whether it is short-staffed or whatever. Because the only standards that the college has established are practice standards, it is only the practising nurses who are held accountable to those standards. So while those nurses are so-called accountable, they are not accountable in the way we need them to be, where their determination of our workload or of how our patient assignment is and of how we practise is going to make our position an area where we are the ones who are challenged and not them.

Ms Babad: This really even goes beyond that. We have disputes with the administrators about their medication administration policies, about their methods of charting, which the nurses are doing but the administrators are deciding how they will do it. If the nurses are concerned that it does not meet the patients' needs, there we have a real conflict. Certainly we have cited some of these in our brief.

Ms Davidson: One of the statements we have made before is that there is a shortage of nurses in this province. There is not a shortage of nurses, but there is a shortage of staff nurses who are willing to work under the circumstances we are being forced to work under. Those of us who stay, why do we stay? Because we want to nurse, we want to look after our patients, we care about our patients and the public, and so we stay. But when you work in an uncompromised situation where the famous floating word in every institution in this province is "cope," it is very difficult and you start looking for something else. If there was room for one more real estate salesman in Parry Sound, I would be gone.

The Chair: Thank you very much for your presentation. I know the committee will give it serious consideration.

COLLEGE OF NURSES OF ONTARIO

The Chair: The next presentation is from the College of Nurses of Ontario. Come to the presentation table and identify yourselves.

Mrs Mandy: We are pleased to have this opportunity to present to the standing committee. My name is Pat Mandy. I am the president of the College of Nurses of Ontario. On my right is Linda Vanginhoven, RNA, of the executive committee. To my left is Margaret Risk, execu-

tive director of the College of Nurses, and Darwin Moore, vice-president of the College of Nurses.

I believe you have copies of our submission that were distributed today. In our submission we confirm our support for some of the issues and identify those areas where we continue to have some concerns. I would like to note that we do intend to make a second written submission relating to the draft amendments that were tabled by the minister yesterday. We need time to study these amendments in order to make an appropriate response.

The College of Nurses of Ontario is the regulatory body for nursing. The College of Nurses supports the policy intent and direction of the proposed legislation. Given the comprehensive consultation process, we have had the opportunity to suggest many changes and see them incorporated into this legislation. Therefore, our submission is brief.

We support the intent of the legislation to increase the emphasis on the identification of deficiencies in and promotion of quality care by practitioners through a quality assurance program. This is a positive enhancement to a process that at present focuses solely on responding to individual complaints.

The review team is to be commended on its review of various models of credentialing and the development of a unique scope of practice and controlled acts model. We welcome the opportunity to work with government and other regulatory bodies to implement the model and evaluate its effectiveness.

There are several areas in the proposed legislation for which we wish to acknowledge support. These include the advisory council, the openness and privacy provisions, the French-language services and mandatory reporting.

There are some areas about which we wish to express our concern and which, in our view, require some alteration.

We support the minister's proposal in the draft amendment to section 5.1 limiting the elected and public council members to a maximum of six consecutive years' service on council. We recommend that the same limitation be applied to the appointment of members of the advisory council and the Health Professions Board.

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The section on minister's powers attempts to reflect a balance of independence for the governing body and its accountability to the minister. The review team had recommended that the minister may request councils to undertake activities. In the bill, the word "request" has been replaced by "require." We believe that "request" reflects more accurately the collaborative nature of self-regulation and is more appropriate to reflect the partnership between regulatory bodies and government.

The fitness-to-practise committee can impose terms conditions and limitations on a member's certificate of competence. A breach of such conditions would be deemed professional misconduct and could result in bringing a member before a discipline committee. We would like to see an additional subsection in the legislation that would provide authority to the fitness-to-practise committee to deal with a member in breach of conditions or limitations. This would be congruent with the intent of the

legislation to address health conditions differently than issues of competence and conduct.

We stated that we would support the intent of the legislation to increase the emphasis on the identification of deficiencies and promotion of quality care by practitioners through a quality assurance process. As the legislation moves forward, there are a number of issues which will need to be clarified either through legislation or complementary government policy. One fundamental concern we have with the legislation is the implication that regulatory bodies can assure quality. Regulatory bodies can assess quality, they can strive for quality improvement, but legislation which implies assurance of quality care can create expectations that cannot be met. We recommend that the terminology in the legislation be changed to "quality improvement."

In reviewing the draft legislation, the College of Nurses, with other regulatory bodies, has identified a number of legal and procedural concerns. The concerns have been discussed with the legal counsel at the Ministry of Health. Since the status of these concerns is not clear at this time, a summary is included to this submission, in appendix 1. Last week, the Minister of Health shared draft amendments that were tabled with you yesterday. After we study these proposals, as I said, we will be making a further written submission to the committee before your clause-by-clause review.

The proposed legislation does not provide for a requirement that the employer verify that the employee is registered. The Health Disciplines Act currently provides for this. We believe a statement of this nature should be included in the new legislation.

We wish to comment on two aspects of the Nursing Act: structure and title restrictions. The scope of practice and controlled acts will be discussed generally, with specific reference to nursing. Throughout the legislation review process we have supported the philosophical thrust of increased public accountability and openness and the increase in public representation on council. The proposed increase of membership to just under 50%, however, affects the principle of peer review and may be perceived as dilution of self-regulation. We have some practical concerns about the structure of the council and the statutory committees with public representation of just under 50%. The College of Nurses is unique in that it represents two categories of practitioners, registered nurses and registered nursing assistants. We have a very large registrant body, of approximately 145,000, and we have a very large council, with 33 members currently.

In the event that the higher percentage of public membership is maintained, the College of Nurses has proposed a structure, which is in appendix 2. This has already been shared with the Ministry of Health. In this structure, public membership is a little over 46% of the college council. This reduced ratio is necessary in order to have sufficient and appropriate representation of RNs and RPNs on statutory committees.

With regard to restricted titles, we recommend that "registered" be included in the title "practical nurse" wherever it appears in the legislation. It informs the public and

other health care practitioners of the credentials of the practitioner.

An exemption has been made to allow a person to hold himself or herself out as a Christian Science nurse, a dental nurse or a graduate nurse. We have accepted the exemption for Christian Science nurse. We disagree, however, with the exemption for dental nurse. "Dental nurse" suggests to the public an individual who is a nurse with a speciality in dentistry. We understand that this title is no longer in use in Ontario. We therefore recommend that this exemption be removed.

We recommend that the title "graduate nurse" be protected. We have been exploring the viability of creating a roster of those individuals currently practising safely as graduate nurses in the province. The inclusion of these graduates on such a roster would allow them to continue working and still provide some monitoring to enhance public safety.

The College of Nurses supports the scope of practice statement for nursing but wishes to note the importance of health promotion as a significant practice component even though the words are not explicitly identified in the statement. We are in agreement with legislation that focuses on the practice of the professions. We recognize, however, that RNs and RPNs are accountable to the College of Nurses for nursing behaviour regardless of the capacity in which they are employed. We also acknowledge that there is a perception of immunity for members working in research, education and the administration dimensions of nursing. We have a responsibility to clarify the legislative intent to members and to inform the public of expectations for all RNs and RPNs regardless of their positions or their employment settings.

There are four controlled acts that are of specific concern to the College of Nurses. We suggest that all controlled acts be very clearly defined. The first controlled act, "communicating a conclusion," which replaces "diagnosis," has been discussed extensively and we join many other groups in expressing concern. We understand that the intent of this controlled act is to limit the determination of a medical diagnosis to qualified practitioners. The College of Nurses supports a controlled act that explicitly limits medical diagnosis to qualified medical practitioners.

The amendment to the controlled act 5, "administering a substance," which changed "on the order of a qualified person" to "on the order of a member of the College of Physicians and Surgeons of Ontario" will create problems for RNs and RPNs working with other health care professions that are authorized to prescribe; for example, dentists or midwives. We have not yet had the opportunity to discuss the rationale for this change with the ministry and we need to consult with nurse practitioners working at advanced levels to ascertain how this might impact on the service they provide. We will comment on this in our second submission.

The lack of definition of forms of energy is confusing. Nursing currently applies some forms of energy, such as bone growth stimulation and phototherapy. If these forms of energy are considered prescribed, then it is important

that nursing have the application component of this controlled act within its scope of practice.

The College of Nurses has supported the inclusion of midwifery in legislation. Throughout the review process we have met numerous times with the Ontario Midwives Association and more recently with representatives of the Interim Regulatory Council on Midwifery. We recognize that in the implementation of midwifery services in Ontario there will be a learning and adjustment period as roles and role relationships evolve. This controlled act is an example of overlapping scopes of practice of nursing and midwifery. The "managing labour" component of this controlled act is not authorized for nursing in the proposed legislation but is currently practised by many RNs and RPNs and is part of the basic education program. We believe it is important to include managing labour as an authorized act for nursing, as it is essential for the safe care of the mother and foetus.

The success of the controlled acts model will depend on an informed public. Freedom of choice and flexibility for the health care consumer and education of the public will require greater collaboration between professions with regard to multidisciplinary practice. The controlled acts model requires an opportunity to be tested and evaluated and that there be opportunity for revision of the act based on evaluation and consultation with the public, the professions and the governing bodies. We look forward to working with the government and other governing bodies in implementing the Regulated Health Professions Act and would be pleased to answer any questions.

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Mr White: Following from this issue, which I know you recognize as being an issue of some debate in your community, is the issue of medical diagnosis. You suggest that you are supporting an explicitly limited medical diagnosis for medical practitioners. I am wondering how communicating information, which implicitly happens in the hands-on practice you represent, might be hampered by that clause or how you would relate to that.

Mrs Mandy: Are you asking why we want it changed to "medical diagnosis"? Nurses have many independent functions which they perform and the wording in the legislation as it is would put limitations on that. The wording now is that nurses cannot communicate a disease, a disorder or a dysfunction, and there are many times when nurses do discuss those things with patients, so that is why we want that limited to medical disease.

Mr White: So you would see that as continually confining what it is that you can do.

Mrs Mandy: What we can communicate.

Mr J. Wilson: I have a general question to you, Madam Chair. There are a number of legal procedural concerns in appendix 1. Will counsel undertake to get back to us on that, or will the ministry be acting through the college?

The Chair: Procedures for the committee are that if you have questions of the ministry, you can ask directly and they can respond in writing, or we will have another opportunity this afternoon. There will be an hour from

time to time and you can pose questions then, but if you pose your questions in writing, ministry staff are here, and normal procedure in the absence of either the minister or parliamentary assistant is to have the response in writing.

Mr J. Wilson: Perhaps I could ask the witnesses what kind of progress you are making with the ministry in clearing up some of these matters—the wording of bills.

Ms Risk: Legal counsel from a number of the colleges have been with working with legal counsel at the ministry and have made significant progress in looking at a number of these, a number of which were tabled by the minister to you people yesterday. Our difficulty is that we just received them the middle of last week and we have not had an opportunity to match them up against the comments we have already made. Some of them will have been resolved and some of them perhaps will not be.

Mr J. Wilson: Will you be doing a second submission to update us on that?

Ms Risk: We will be doing a second submission. Some of our concerns are almost a matter of form and are not particularly substantive and some are a little more substantive.

Mr J. Wilson: I appreciate that.

Mr Beer: Your organization and the association that appeared just before you clearly have different approaches to this legislation. As we look at some of the points that were raised previously, I know you were here, and I am sure you have talked with people from the Ontario Nurses' Association about that. But what is the nature of the disagreement here, because I think as committee members it is important that we understand in terms of the college, the Nurses' Association and the third association, which is gone out of my head for the moment.

Mrs Mandy: There are actually four nurses' organizations in Ontario. The College of Nurses of Ontario is the regulatory body for nursing. The Ontario Nurses' Association, which just presented, is the union for registered nurses in Ontario. The Registered Nurses' Association of Ontario is the professional body for RNs, and the Ontario Association for Registered Nursing Assistants is the professional body for RNAs.

Mr Beer: Okay. Am I correct that your association and the registered nurses' association have said that in principle you support the legislation, that you have some questions, but that basically you have supported that? I guess what I was really after is, in terms of the major concerns that were expressed by the ONA, do you agree that those are concerns but simply feel that the legislation deals with them adequately, or do you not feel that those are as critical as the ONA put to us? I am trying to get some guidance because I want to get a sense of—

Mrs Mandy: I believe that we approach them from our own perspective. As the College of Nurses of Ontario, protection of the public is our mandate. The Ontario Nurses' Association is the union, and represents the RNs' interests.

Ms Risk: I think that probably the scope of practice is the area that is most fundamental in our differences. It is a

new model and it has been, I think, a difficult one for all of us to grapple with during the process. It is a much more open model and actually we would disagree that it is restricting; it is rather just the opposite. It provides much more independent decision-making for nurses. So the broad scope of practice is something that we have certainly supported as something that supports consumer choice in a system that is much more multidisciplinary and has many more grey areas between professions than there used to be. The controlled acts: I think we have supported the model in taking a try at it. We all have some concerns about whether we will have difficulties with enforcement, but it really is a very unique approach that has sparked interest right across Canada and the States. We think that we probably can make it work. It is not just our organizations that actually disagree. We all are trying to look at a new model and how it is going to work.

The Chair: Thank you very much for your presentation. The committee will look forward to receiving your written brief and any other further communication you have as the hearings go forward.

1050

VICTORIAN ORDER OF NURSES

The Chair: The next presentation is from the Victorian Order of Nurses. Introduce yourself for the committee, please. You have 20 minutes for your presentation and I would ask that you leave time for questions if possible.

Ms Suttie: Yes, I will. Actually, our remarks are going to be very brief. I am Jane Suttie, the associate provincial director of VON Ontario, and this is Judith Layzell, the director of quality assurance for VON in the province. We did not hear any of the presentation that took place before us, so we will probably be unable to comment on that. Basically what we would like to do this morning is just make a couple of what we feel are important remarks in relation to Bill 178. We will be presenting a formal paper by the end of the month, which is the deadline that was given, but due to holidays and so on we were unable to gather all the people together we needed to do a formal presentation. So please bear with us.

When we reviewed the paper, one of the things that came to mind under the heading of advisory council was the fact that we would like to see some consumer representation on that council, and also that the organization of VON would be prepared to act in a consultant capacity to the advisory council should it be implemented. In essence we support the process but we would like to see a more blended group of people; for example, government representation, some professionals and consumers so that you will get a broad representation there, and participation.

Under the prohibitions there are a few comments we would like to make. It is our understanding that the concept of limiting controlled acts is applicable to acts considered to be potentially harmful to the public. We feel that this paper hopefully is for the protection of the public. I know that as an organization we are very interested in the protection of the public and would like to see this really reinforced under the legislation. However, we feel that it appears somewhat hierarchical and perhaps unnecessarily

so because of the actual existence of the scope of practice for people in the various professions.

We are not sure that the recognition of the team approach has been given due consideration as well. When we speak from the community perspective, there are a lot of various professionals who go in to take care of the patients, and hopefully we are working as a team and not just as individuals in that community setting.

Section 26 gave us some difficulty. Again, we will have to clarify this at a later date when we have the appropriate people to have the input, but the act has implications for relationships between physicians and midwives, particularly when the client-directed care is exercised. If we look back at the long-term care reforms, one of the things that was being advocated was perhaps an increase in client-directed care. I think we should keep that in consideration when we are looking at the act in itself. The issues will have an impact on the VON. For example, can nurses act on the order of the midwife? Can nurses assist with the delivery after the care in the home? These issues, we felt, were not really clear in this particular act and we would like to have it looked at a little bit more closely.

Section 30: The title of "doctor" is a degree earned by many health care professionals, and we feel that any professional who earns a doctorate should have the right to use it. For example, a basic degree in psychology does not grant the title "doctor" such as optometrists and dentists, etc, have. This is really applicable to nursing. A lot of nurses—not a great many, proportionately speaking—do go on to get a doctorate in nursing but they are not, at this point, calling themselves doctor. We feel that should be changed and permitted. In other words, I guess what we are saying is that if we have a doctorate in nursing, do we have to go to the council to get an exemption to use that title we have earned?

The references to quality assurance and continuing competence under section 78 appear to be inconsistent. It is unclear if the function of the proposed quality assurance committee is actually quality assurance or monitoring of competency. We would like to have some clarification of that. It is the VON's position that quality assurance should be the responsibility of the funders of the system. Let me enhance that statement a little bit, because I guess what we are seeing in the community are a lot of agencies that are providing community health care. However, we feel that if some quality assurance criteria were in the legislation, then all agencies or providers that would be responsible for providing that care would have to meet those criteria.

One interesting thing that came to mind with section 91: When you talk of premises in relation to the provision of health care in the home, we feel this needs some clarification because we are in kind of a unique position. We feel the client's right to privacy must be respected, and due to the increasing utilization of charts in the home, the client's permission to access his or her chart is essential. That is where the chart will be in the future. It is, in some agencies now, and we are taking that route as a provider agency as well. It will not be at the employer's office; it will be at the patient's home. So the document will be there, and to access it we feel we should have the patient's permission.

We feel that the legislation falls a wee bit short of covering all the health and social service workers in the community. For example, we hear a lot of discussion about whether it is a multicompetent worker or whether it is a home health aide or homemaker. For these paraprofessionals we think their methods need to be defined to ensure there are good relationships between the professionals and the paraprofessionals. It is our prediction from reading the various trends in government and the community in general that there will be a significant increase of the paraprofessionals in the future and we must ensure that the protection of the public is recognized in these areas.

One final comment is that the reality of the 1990s is the control of health care costs. Diversification of staffing to include the less costly categories of staff, such as the ones mentioned a few minutes ago—home health aides—would be helpful. However, we recommend that the government establish some sorts of funding formulae or criteria to recognize the utilization of these paraprofessionals. This is over and above the fact that we should have some legislation covering the home health aide or multicompetent worker, whatever the individual ends up being called. Educational standards which can be appropriately monitored are equally important.

These are just really a thumbnail sketch of our comments and, as mentioned, we will be doing a full report by the end of the month. Not being a clinician, if there are any clinical questions, I may have some difficulties with those, but I will try my best to answer them.

Mr Johnson: The Victorian Order of Nurses has a reputation and a history of being the nurses of choice in supplying nursing care to people in their homes. As we try to cut costs in the province, we know there has been some conflict recently with regard to for-profit enterprises that are in competition with the Victorian Order of Nurses, and that is maybe a side issue.

The thrust of the legislation is to reduce unnecessary restrictions on who can do what and to create opportunities for more efficient use of human resources. Can you comment and give some indication on what these opportunities might be in the delivery of health services in the home?

Ms Suttie: You are talking of the paraprofessionals?

Mr Johnson: I did not want to get into conflicts between paraprofessionals with regard to who can do what. This legislation, although there has been some comment, maybe is not as comprehensive as I like to believe it is. It is supposed to reduce these unnecessary restrictions. I was just wondering if you could comment. It is supposed to create opportunities. I was wondering if you could give me some indication of what you think these opportunities might be.

Ms Suttie: I have no doubt that it does create opportunities as far as the act is concerned. Primarily what we are saying is that it needs some clarification in some specific areas. In general, we think that the prime thing as far as any legislation is concerned, particularly in this type of legislation, is protection of the public and that any providers or regulating bodies or what not will have to look at this as a primary focus for their work.

As far as opportunities go, I think there are many, although I am really not in a position to say what they would be. I do not know if Judith would like to comment on that.

Restrictions are necessary to a point, and I guess when we are talking about the introduction of—staff diversification is one of the things we are looking very seriously at in our organization to ensure that we are providing safe, effective, quality, cost-effective care to the patients in the community. In order to do this, we also must realize that some of the people we may be introducing into the organization as staff members are covered under some sort of legislation. In other provinces, for example, the category of home health aide is currently utilized and covered. In Ontario we are unable to diversify our staff to meet that need in that category of staff because we have no legislation to cover it, and basically this is where we are coming from.

I do not see that as a restriction. I think it is an opportunity, once the legislation is changed. Am I answering your question?

Mr Johnson: Yes. We are all interested in the protection of the public. Would you agree that this legislation is a step in the direction of better protection?

Ms Suttie: Yes, I do. We very much support it in that respect.

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Mr J. Wilson: You mentioned something about recognition of the team approach, and I assume you are referring to the scope of practice there. Is it not sufficiently general to capture everyone on the team? I am just not quite sure what you meant by that.

Second, quality assurance in the setting of criteria: It is my understanding from reading this—although you are absolutely right, it is very vague in what it means, and we have not had the discussions with the ministry you have probably had and certainly other nursing groups have had about what that will mean. What is your understanding of “quality assurance criteria will be set by the advisory council,” and are you invited to participate in that?

Ms Suttie: Judith may want to add a comment or two on quality assurance. Obviously, the regulating bodies will be monitoring the competence and so on of any practising professional in the province. However, when we look at the various groups that are currently providing health and social services in Ontario, there is very little to establish criteria to say I can perhaps go tomorrow and start a business and provide health care in the community. There are a lot of mom-and-pop operations which are doing very good jobs, but there should be some criteria established that if you want to provide these services, then you have to meet these criteria.

Your professionals, on the other hand, will be monitored by the regulatory bodies. So it is an added step of quality assurance in one way, I guess, although I feel it is necessary, or we feel it is necessary, to ensure that all of those who provide those services in the community or elsewhere do have some criteria they must meet in order to set up business. So that is where we are coming from.

Mr J. Wilson: And the scope of practice?

Ms Suttie: Again, this is more of a clinical issue and I am not all that well versed on it, but we were looking at it in the context of a variety of professionals going into the home to provide the service. We act under the orders of a doctor, obviously, but the team approach is critical. If the physiotherapist is given an order from the doctor and we are assisting the physiotherapy, it is within our scope of practice to do some of the activities that are related to the work that the physiotherapy would ask us to do. So it is indirectly an order from the doctor, but it is not direct. In the team approach, it could be a doctor giving an order to a physiotherapist and nurses and so on and so forth who would be going into the home to do that.

Mr J. Wilson: Have you had legal problems in that area in the past?

Ms Suttie: Not to my knowledge, no.

The Chair: You are welcome, as all groups or individuals are, to communicate with the committee in writing and present briefs. Please feel free to do that, and thank you for your presentation today.

Ms Suttie: Thank you for the opportunity, and we are, as I said, preparing an appropriate brief.

BOARD OF DIRECTORS OF PHYSIOTHERAPY OF ONTARIO

The Chair: The next presentation is from the Board of Directors of Physiotherapy. Please introduce yourselves. You have 20 minutes for your presentation and we would ask that you leave some time for questions from members at the end of your formal presentation.

Dr Avison: Thank you. I am Dr William Avison and this is Ms Gillian Firth. We are both members of the Board of Directors of Physiotherapy of Ontario. We have distributed our brief, and it does have an executive summary, so we would like to speak to some of the issues there and leave the rest for you to pursue at your leisure.

The Board of Directors of Physiotherapy of Ontario is the regulatory board for physiotherapists and physical therapists in the province. The board is appointed under the Drugless Practitioners Act and the board administers and treats through the practice of physical therapy, sets practice guidelines, receives complaints from the public regarding physiotherapists and undertakes disciplinary action when necessary. At present there are approximately 4,400 registered physical therapists in the province practising in various settings, both in institutions and in the community. The registrants are 90% female. The board's makeup is a five-member board of physiotherapists and one public, who is myself.

In general, the board is very supportive of the new legislation and has actively participated in the discussions and processes which have brought the act to this juncture. We believe that the original Drugless Practitioners Act has become outdated and we believe it presently limits the board's ability to fulfil its mandate to protect the public interest. We think that this new act will give us many advantages in this area and we welcome its objectives.

We are especially happy with some of the aspects that will protect the public from unqualified, unfit or incompe-

tent health care providers and that will encourage the provision of high-quality care, especially in terms of providing guidelines for quality assurance and continuing competency. It will also give the public, we believe, freedom of choice within a range of safe health care options, and it will allow for the evolution of the roles of individual professions in order to deliver a more effective health care system.

The other point we would like to stress here is that we feel strongly that a major advantage of this new act is that it will give greater public participation in the various colleges and regulatory bodies.

Having said that, we have two concerns we would like to raise here. The first concerns subsection 15(1) of the Physiotherapy Act. That passage reads, "No person other than a member shall use the title 'physiotherapist,' a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals."

As this is written, the term "physical therapist" would not be restricted. We believe strongly it is essential that both the terms "physiotherapist" and "physical therapist" should be restricted in order to protect the public. Indeed, elsewhere in the Physiotherapy Act, in clause 6(1)(c), the term "physical therapy" is also used, and this is an issue that we would like to draw to the attention of the committee concerning a possible amendment here.

The title "physical therapist" has been restricted in Ontario since amendments to the Drugless Practitioners Act in 1983. The protection was afforded in recognition of the changing nomenclature in the profession in North America. You will see in our submission that most university programs in Canada use the term "physical therapy." We also present some information in schedule B of the brief illustrating that the status of physiotherapists and physical therapists are used interchangeably.

It is our view that if this is not protected, the public itself may become very confused. Indeed, we have been talking with people from the Consumers' Association of Canada who expressed to us the fact that any distinction between physical therapist and physiotherapist will be extremely confusing for the public. For these reasons, the board requests that the committee include "physical therapist" as a protected title in the Physiotherapy Act.

The second point we wish to raise here concerns subsection 26(2) of the Regulated Health Professions Act concerning the issue of communicating to the individual or his or her personal representative a conclusion identifying a disease or disorder or dysfunction. This is the clause concerning diagnosis and assessment.

Like many professionals in the health care system, the board is extremely concerned about the impact of this decision, which appears to include not only diagnosis but also the conclusions of an assessment.

Physiotherapists routinely communicate to their clients the findings of their assessments of physical disorders or dysfunctions. It is necessary to the patient so that the patient can understand his or her condition, and it is also important if the physiotherapist is going to get informed

consent to engage in further treatment. It is important that this be communicated.

We believe that the current clause is not in the best interest of the public. We feel it is only natural for the client to discuss the findings of his or her assessment with the individual who performed it, in this case a physical therapist, and we feel that this situation is contrary to the stated objectives of the legislation to give the public freedom of choice. We think it is important to balance the public's right to protection against practitioners who may communicate conclusions which are outside their scope or expertise, but we believe that it is important that physical therapists have the right to practise autonomously and to communicate their assessments to patients.

There are other issues we have raised and other points we have mentioned to reinforce our concerns about these two issues, but I think in general we would like to state that we are enthusiastic about the legislation and, except for these two issues, we heartily endorse it.

1110

Mr J. Wilson: In your discussions with the ministry, and I assume with the review committee prior to that, why will they not give you protection for the title "physical therapist"?

Ms Firth: Their reasoning seems to be that they want to limit the titles that are restricted as much as possible, and the one they feel is most used in Ontario is "physiotherapist." We disagree.

Mr J. Wilson: Second, you said it is common practice for physiotherapists to communicate a diagnosis.

Ms Firth: It is more an assessment and the physical dysfunction. I do not know if you have had physiotherapy yourself, but people here who have can probably relate to this. You get referred to a physiotherapist or physical therapist with a diagnosis, say, of back pain. The physical therapist then has to look at that back pain and decide if it is muscular, ligamentous, joints or what it is and then discuss this with the patient before carrying on into the treatment. It is going to limit the amount of education we can give a patient and the amount of explanation we can give regarding treatment.

Mr J. Wilson: Have you put forward a suggested amendment?

Dr Avison: Yes, we have.

Ms Firth: We would like to be able to communicate within the scope of our practice, and the scope statement is in the body of the brief.

Mr Beer: I would just like to follow up on that and try to understand, because I think this issue around diagnosis and assessment is one that is going to come up with a number of groups. Could you give us an example of something you feel you could do today but that under this legislation you could not or ought not to do.

Ms Firth: Yes. As I was saying to Mr Wilson, it is really a question of how we communicate the findings of our assessment to the patient, having done the assessment. The patient will come, maybe with a disease, with a diagnosis already. They may come with a diagnosis of multiple

sclerosis or a stroke or rheumatoid arthritis. The physiotherapist will then look at that person and decide that the pain may be coming from a certain joint and how to treat that pain, or the muscular dysfunction or whatever. Then we have to discuss that with the patient in order to establish a treatment plan. It is that discussion that we feel we will not be able to do with this legislation.

Mr Beer: You would not be able to discuss your assessment if you were dealing with me and say, "Look, we know people think it's something to do with the muscles, but we see a problem with the spine," or some such thing.

Ms Firth: Yes. It is likely that it would be muscle weakness or a soft tissue injury, something like that, which we would have to zero in on and explain to you. We would have to educate you as to the sorts of things you can do at home or the exercise routine you can do.

Mr Beer: Have you had a legal opinion from your people on the way this would be worded, or is worded?

Ms Firth: Yes. It says "communicating to the individual...a disease, disorder or dysfunction," which one would assume includes physical dysfunction.

Ms Haack: I would like to follow up on that. Personally, I have not had a need to use the services of a physio at this point, but I guess my question centres around the whole process of how I would get a physiotherapist's services. I assume, and I hope you will correct me, that if I needed your service I would basically be referred by a doctor and that would hold true now as well as later.

Ms Firth: No, there has been a change in this proposed legislation.

Ms Haack: If I have tennis elbow, I can choose to go directly to you.

Ms Firth: That is correct. Presently you cannot. With the present legislation you have to be referred by a physician.

Ms Haack: You are concerned that if I came to you with tennis elbow, what I deemed to be tennis elbow, then after your assessment of that your assessment would have to be communicated by a doctor and that you could not, under your scope of practice, tell me that I have tennis elbow and then outline a series of exercises or treatments that might be possible.

Ms Firth: That is correct, and also, if you came on a referral from a physician the same would apply, even if you came with the diagnosis of back pain. We would not be able to tell you where that pain was coming from.

Ms Haack: Okay. Thank you for making that absolutely clear for me.

Mr Callahan: I just want you to enlarge on the "harm" clause, why you feel that to be the case.

Ms Firth: We feel that having it in there may leave some professions that are not regulated, such as social workers, psychotherapists and clergymen, open to being prosecuted under that clause.

Mr Callahan: For what? In terms of exceeding their parameters?

Ms Firth: In terms that they would be limited by the controlled act. Therefore, they also would not be able to

communicate their assessments to the people they are treating.

Mr Callahan: My colleague asked you whether you had a legal opinion on the question of communicating to the individual, etc. Would you be prepared to share that with us?

Ms Firth: I think it is basically what I explained previously, that we would be limited in our current practice.

Mr Callahan: Is that what the legal opinion says? Do not let me pressure you for it. It is your legal opinion; I do not want—

Dr Avison: That is what our legal counsel has advised, his interpretation of what the legislation would mean.

Ms Firth: We believe it was not the intent of the legislation to limit what we do, but we believe the wording that has been chosen will do that.

Mr Callahan: Does your legal counsel suggest some more appropriate wording as an alternative?

Dr Avison: No, not at this point.

Mr Owens: Just to digress for a moment, Mr Avison, you have a PhD and there have been some issues raised with respect to the use of the title "doctor" within the medical profession or the allied health professions. Do you see that this legislation would inhibit you and your use of that title, and what do you propose to the committee in terms of amendments?

Dr Avison: Let me speak as an individual and not as a member of the Board of Directors of Physiotherapy on this, because this is not an issue that has come up at the board. My PhD is in sociology. I am a medical sociologist, but I think there is a problem. I suspect the problem is that in the legislation, as it is proposed, there is a selection of

which individuals may use the term "doctor." A psychologist may. A PhD in nursing obviously may not, from what we see in the legislation. A PhD in speech pathology does not appear to be able to. I think it is a somewhat arbitrary aspect of the act and, personally speaking, I am not certain how easy it would be to enforce. I think I can speak for colleagues of mine who also have PhDs; they probably do not accept this aspect of the act as being useful or particularly important, but I think the major issue is how that aspect of it can be enforced. It seems very difficult.

The Chair: Thank you very much for your presentation. If you have any additional information, documentation, briefs or legal opinions you would like to share with the committee, please feel free to table them with us at any time.

Dr Avison: Thank you.

The Chair: For the information of committee members, the clerk has received documents from ministry officials that were the basis of some of the information received yesterday. There is one copy. If it is acceptable to everyone, it will remain in the clerk's office all of this week, where any of the research staff from the caucuses can have access to it. At the end of that week we will turn it over to the research under Bob and Alison, and it will then be available through them, if that is acceptable to everyone. Agreed?

Second, I remind everyone that we will be reconvening at 1:30 for a presentation from ministry officials for approximately one hour. Thank you all for attending this morning; meeting adjourned.

The committee recessed at 1120.

AFTERNOON SITTING

The committee resumed at 1336.

MINISTRY OF HEALTH

The Chair: Because of a change in scheduling, the ministry presentation can continue until approximately 2:40. That leaves some time for discussion and questions. If it is the will of the committee, the procedure will be similar to yesterday's. The 2:40 presentation, the Pentecostal Assemblies of Canada, western Ontario division, has been cancelled.

Welcome back. I think we had completed section K and we were going to begin section L. All members have a copy I believe. Please begin, Ms Bohnen.

Ms Bohnen: I am going to start by talking about the issue of diagnosis. First of all, before we come to the documents in the folder, I would like to give you some background on how diagnosis or an aspect of diagnosis came to be included in the controlled acts. The review started the selection of controlled acts for the legislation by asking all the participant provider groups to list those activities their members perform which in their view were the most dangerous.

Every profession made a list of the things they considered to be dangerous, and diagnosis appeared on the list of a number of groups including, and probably most particularly, that of the medical profession. They felt that diagnosis was potentially very dangerous.

The review then embarked on an exploration of the risks associated with diagnosis and what approach the bills might take to try and contain those risks, because when most practitioners think of diagnosis, they think of the information-gathering process, the application of diagnostic tests and procedures; then they think of the cognitive process whereby they subject the information they have collected to a thought process, organize it, apply information they have learned, apply their judgement to it and then transform it into an entity which is then communicated to the patient.

The review believes that the part of the process whereby information is gathered, such as the performance of diagnostic tests, some of which may be hazardous—all of that activity would probably be covered by other controlled acts that focus on the performance of particular activities; or other legislation covered that anyway. For example, X-ray is covered by legislation, lab testing is covered by legislation, invasive physical examinations are covered by the controlled acts.

The cognitive part of it was quite tricky. How would you go about controlling what anybody thinks? Would you really want to try to control what anybody thinks? I think the answer to that is no. You would not want to do it and if you did want to do it, you could not do it.

Interjections.

Ms Bohnen: I walked into that. In any event, the review concluded that it was impossible and inadvisable and silly to contemplate controlling the thought process in any way. This led them to the actual communication of the

product of all of this effort, which is telling the patient what is wrong with him. When you get right down to it, that is what this is about, telling the patient what is wrong with him.

Why is that hazardous? Because if you get it wrong patients might agree to the wrong course of treatment. They might make life decisions that are very inappropriate given what is really wrong with them. You have to be careful what you tell people when you tell them what is wrong with them. I think there was consensus among the participants; most of them said yes. The province, the government was appropriately concerned about the telling of people what is wrong with them, but when it came down to figuring out how to control it, that is where all these difficult issues arose.

First of all, some groups at one extreme of the continuum, I think, would say you do not really have to control this at all. It is a free country, an adult does not have to go to a physician at any time in his or her life. Most people choose to do so, and you are free to go to any provider you want. People should bear full responsibility for all the diagnosis they get or do not get. But that seemed to be a pretty extreme position, not one that most participants or very many governments would agree with.

On the other hand, at the other extreme of the continuum, you could say that we are never going to let anybody except a physician tell a patient what is wrong with him, no matter what that communication might consist of. That would really mean you could never go to a non-physician unless you had first gone to a physician, and the physician had said: "Okay, go to the physiotherapist, to a chiropractor, to whomever."

It would really reinforce the physician as the supreme gatekeeper for all services, both regulated and unregulated, and that did not seem to be a very sensible or enforceable position either. That is not what people want; it is not what is necessary. The cost associated with it would be rather astronomical.

So that left the review with the task of trying to differentiate between those situations or communications where you really should only go to certain practitioners to find out what is wrong with you and those where many other practitioners are quite competent to make this communication.

The words which the review proposed to achieve this were somewhat different from what finally appeared in the bills. The proposal that appeared in *Striking a New Balance* simply gave diagnosis as the controlled act; but then it gave a particular meaning to diagnosis. The words were "diagnosis" means the communication to a patient, or his or her representative, of a conclusion as to the cause or identification of a disease, disorder or dysfunction." I guess the key words were "the cause or identification of a disease, disorder or dysfunction."

The review, in contradistinction to that word "diagnosis," used the word "assessment" to mean something which all regulated providers could engage in. That was something different from diagnosis, and they included that

word "assessment" in the scope-of-practice statements of most of the regulated professions and they gave that word "assessment" a particular definition.

For example, in the Denturism Act that was proposed by the review, the scope of practice included the assessment of partially or fully edentulous arches. An assessment was defined by the review as the evaluation of a patient's physical or mental state in order to determine whether a treatment within the health professional scope of practice is appropriate to the patient's condition, and if so, in what manner it ought to be applied or administered. It includes the communication of evaluation to the patient and his or her representative.

By including this definition of assessment and the word "assessment" in these individual health profession acts, the review intended to signal that even if they could not perform the controlled act of diagnosis, they could nevertheless perform an assessment and communicate the results of the assessment to their patients.

This report was tabled in the Legislature and the legislative counsel was instructed to draft bills based on this recommendation. The then Minister of Health and ministry staff continued to hear representations from interested groups as to the impact they thought this would have on their practices.

The legislative counsel in particular really tried to transform what we viewed as the essence of this into language that would be clearer and would actually have some legal effect, because just sticking a definition of assessment, for example, in the individual health profession acts was not an effective way of authorizing these individual health professions to assess their patients. You cannot just stick a definition in another statute and expect it to contradict a provision which says you cannot diagnose. You cannot read bills that way.

We came up with the provisions you see in section 26 of the Regulated Health Professions Act. Because we were responsive to criticism that the definition given to diagnosis was a pretty artificial one, we did not even use the word "diagnosis" any more. Instead, we came up with the controlled act that you see in subsection 26(2).

Consideration was given to saying something such as you see here, and coupling with it a provision that might have said, "Despite this, you can do an assessment"; but we were pretty convinced that it was more appropriate to try to define what you could not do so precisely that it would be abundantly clear to all and sundry that they could do everything else.

That is one of the main reasons for this rather lengthy formulation of the controlled act. We really thought that if it was very precise, people would take comfort from it. We know now, of course, that many groups have not taken comfort from it, and I think, before we talk a little bit about the reasons why they are not taking comfort from it, it might help to flip to the first document in that tab, which is called *Diagnosis: Three Perspectives*. It reflects some work that a ministry intern, working at the professional relations branch, did on different approaches that different practitioners take to diagnosis.

Nearly all physicians practising today, and most regulated health professionals, see diagnosis as the process whereby they collect and analyse information to discover the cause of someone's symptoms. That is the traditional western way of diagnosing patients, and that is what physicians and most regulated health professionals mean when they give someone a diagnosis. But it is not the only understanding that people have of diagnosis.

The second way of thinking of diagnosis is labelled here as systemic. It is based on the view that there is no single cause for most illnesses or most sets of symptoms. Instead, diseases result from the interaction of individuals to their environment. It is multifaceted; there are social causes and environmental causes.

Practitioners who adopt this understanding of diagnosis have a much broader view of what it means, but they still often use the word "diagnosis," and I think the fact that they are using the word "diagnosis" to mean something different from what most health professionals mean when they use the word accounts for some of what we are hearing.

Perhaps a clear example of that is what we have heard from social workers. Social workers use the word "diagnosis" to refer to a social work diagnosis, an explanation in the terminology and the understanding that social workers have of family interaction, social interaction and so on, to explain why an individual is experiencing particular distress. But it is not the same kind of diagnosis that a physician gives when he or she says to a patient, "You are suffering from manic depression or schizophrenia." It is a different kind of diagnosis, but all these groups are using the same terminology.

There are other philosophical understandings of what diagnosis is all about, but for our purposes, I think it might be helpful to keep in mind that we are using that word "diagnosis" in this controlled act in the traditional, conventional, western medical way of thinking, which is to say that, yes, we know people exist in an environment, but the diagnostic process is a process of finding out the specific cause of a particular set of symptoms.

1350

The next document under that tab, as you can see, includes a recommended ministry response to the concerns the ministry heard over the past year or so about the way the controlled act was expressed in the bill. I think it is worth focusing on the fact that this set of words contains four very important elements, all of which would have to be proven to sustain a prosecution, because I think some of the concerns that are expressed are based on an incomplete understanding of all of the elements of this controlled act. That may be the fault of the language, which probably can bear some improvement, but we really remember that the controlled act only focuses on communications to patients or their representatives and does not control at all communications among members of the health care team, so that nothing, for example, would stop a nurse from communicating to a physician her sense of what is wrong with this patient.

Second, the communication must be in the course of the provision of health care services to individuals. I know that some teaching groups have expressed some concern

that when they talk to their students, they may inadvertently transgress this controlled act. I think the ministry's view has been that, yes, health care services is an elastic term, but it probably does not extend into the classroom when teachers are talking to their students, and it does not extend everywhere.

Third, it must be reasonably foreseeable that the patient will rely on the conclusion that is being communicated, and this is an attempt really to focus on those first communications where the news is being delivered to the patient, "This is what is wrong with you." So it would have no effect on subsequent discussion with the patient, such as many health practitioners engage in to help people manage and understand their condition.

Finally, it must be a conclusion, like a conclusive statement, that does identify a specific disease, disorder or dysfunction as the cause of the patient's symptoms. All of these elements must be present.

Mr Hope: You are talking about a direct conclusion, a disorder or a dysfunction. An alcoholic, for instance, goes and sees an AA rep who diagnoses him as being an alcoholic; he comes right out and says he is an alcoholic. Because an alcoholic is now designated under the medical terms, is, what that worker has done then against this legislation?

Ms Bohnen: I think the question you ask points to the issue of, first of all, is there going to be definition of disease, disorder or dysfunction? There are many classification systems for health conditions, and one of the ones we hear a lot about is DSM3R, which is an American classification system for psychiatric conditions.

The fact that a condition is listed in one of these books as a disease or disorder or dysfunction, and somebody applies that label to a person in answer to a question or in a conversation, does not transform it into a conclusive statement telling the person that the cause of his symptoms is such and such, that he suffers from this or that. There is a distinction between the two. But to try to answer your specific question, when somebody who is an AA rep tells the person that—I would not say that the AA rep, for starters, is providing health care services.

Mr Hope: But take away the health care services and look at the picture of an individual, one-on-one conversation. I am doing an analysis of the state of your mind right now, or whatever the state of your affairs is, and I am doing an assessment on an individual. I am putting all the pieces together and then I am coming up with a conclusion, saying: "You are an alcoholic. You need help, and we are going to put you in one of the fine institutions we have here in Ontario."

Mr White: There are a good many people who are health professionals, who are addiction counsellors, who would come up with that kind of conclusion, who are employed by the Ministry of Health. Would they be precluded from doing that?

Ms Bohnen: They are not precluded from providing assessments, and you cannot wave away the health care services context to this. In your question you started with that, leaving that aside. You cannot leave it aside. What we are trying to say is that all of the elements of the section

work together. But I do not think that you want or the ministry wants or the government wants a system whereby addiction counsellors and all of these other people who are employed by the Ministry of Health and other institutions counsel people with alcoholism and other illnesses. That is not what this is intended to stop, and the challenge has been to try to come up with the exact concoction of words, so that assessment and counselling activities continue without interference and without people fearing that they are going to be prosecuted for what they say, without at the same time unleashing unqualified diagnosticians on people.

Mr J. Wilson: Would it not be possible to put the definition of diagnosis and assessment that you are using in either the definitions section of Bill 43 or one of the acts?

Ms Bohnen: Sure. I do not know that you just want it as a definition. If the committee advised and if the government felt that a solution was to say something like, "despite this controlled act an assessment is possible" or "diagnosis only means this" or "an assessment means that," yes, by all means that is possible.

Mr J. Wilson: It might not be a bad idea. You have given us different versions of definitions of the word "diagnosis" and it would help a reader of the acts to know and I think it would help a court to know what the ministry or the government had in mind as a diagnosis. Or is there an accepted norm?

Ms Bohnen: In terms of what is the disease, what is the disorder, what is a dysfunction? The bills do not define those terms and I think it would be very difficult to define them. What you would expect if this were in court would be that expert evidence would be adduced by the relevant health experts as to what the condition was, so that would be taken care of best in that fashion. The other thing that is worth bringing out is that there are a series of statutory exceptions to this controlled act already contained in the bill and they are set out in section 28, so you should be aware of those. For example, treating by prayer or spiritual means, that is a religious healing exception, that can take place without fear of transgressing that controlled act—clause 28(d) treatment within a person's own household.

In addition, there are delegations. As you heard the minister clarify, it will be very clear from the bill that any controlled act can be delegated. In many practice settings where people who are not physicians are providing diagnoses to patients today, it is because this function has been delegated to them. They are, at least nominally, being supervised by a physician, or a psychometrist is being, at least nominally, supervised by a psychologist. So there is a certain chain of command to ensure that there is quality assurance in the diagnoses that are being given out to people.

Mr J. Wilson: So what you are saying is it would be difficult to actually define the term "diagnosis" without also having to define dysfunction and disorder.

Ms Bohnen: No, I am not saying that. I do not think it is necessary to define disease, disorder, dysfunction and I think it would be very, very difficult to do so usefully. I think when it is an issue, expert evidence should be brought to the court that defines it.

Mr J. Wilson: What about diagnosis and assessment?

Ms Bohnen: The approach we have taken so far to try to define diagnosis is we have tried to be more and more precise. But the more precise we have been, it seems the more uncomfortable people have become. So I think the approach may be not to try to be more precise but perhaps to consider being more general and, as well, to consider giving some clarification about assessment and what that means. Those are the things the minister alluded to that we have been struggling to try to come up with.

1400

Mr Callahan: It is a fairly horrendous fine for a breach of subsection 26(1). It is not more than \$25,000 or imprisonment for a term of not more than six months or both. Has any thought been given in subsection 26(1) to taking that out of the vein of being what would be a strict liability offence to put in the words, "No person knowingly shall perform a controlled act"? I think it is interesting because this is going to be a lawyer's dream. Each of these cases is going to be decided. I mean my colleague over here has presented one which I thought was pretty good. There are probably a million of them out there that you have not thought of, and I cannot honestly believe that any government could ever think of all of them.

That being the case, if the person is innocently doing something, we really do not want him to be subject to up to a \$25,000 fine or six months' imprisonment or both. So if you put in the words "No person knowingly shall perform," it might make it a little more difficult for whoever is prosecuting to have to prove knowledge, but at least it would eliminate the innocent person.

The other thing too is it seems to me that the harm clause becomes of some importance in light of what is being said about 26, because if you have a harm clause in there, then you have got a different criterion to apply to those people who do it but reach that harm clause. So you have got, as it were, two guidelines to prevent the public from being dealt with in a way that this bill is trying to safeguard them against.

Has any thought been given to putting the words "No person knowingly shall perform"?

Ms Bohnen: Yes.

Mr Callahan: Or wilfully, maybe?

Ms Bohnen: It was our view, as I recall when this drafting was going on, that constitutionally the word was implicit because with the application of the charter, a defence of due diligence and reasonable mistake in fact would exist anyway.

Mr Callahan: That is the middle guilty mind; that is not the big guilty mind. That is somewhere between strict liability and mens rea as it is understood under the Criminal Code. That was held in cases about careless driving because it carries a jail term with it, or any crime or any quasi-crime that carries a jail term with it. But what I am suggesting is taking it a step further, beyond the due diligence defence to one of true mens rea. What you are really looking for are people who are bad people, who are going to try to get around this act. You do not want people, I do not think anyway, to sit down and be advising someone or

doing good work for the community or for people and have to worry about whether they need a Philadelphia lawyer sitting next to them as to whether or not they have gone over the limit. I do not think that can happen, if you have "knowingly" in there. Rather than just making it that middle mens rea, you make it an absolute mens rea. Then in fact you are catching the people who want to skirt the act. If they are not people who want to skirt the act, then why not give greater latitude to those people and not perhaps have to have them be treated for stress because they are worried about whether they are breaching 26(2) 1, 2, 3, 4.

That is my contribution, Madam Chairman. I will be leaving at the end of the week.

Mr Beer: The example we heard this morning from the physiotherapists—not being a lawyer, I have been wrestling with this. I keep trying to find concrete examples of the concern they raised and I guess also the one that Ms Haecck raised around the tennis elbow. Now something says to me, common sense dictates that if a physiotherapist said to me, "Charles, you've got tennis elbow," that cannot be a big problem as an assessment. Clearly this would be something that physiotherapists would know, that indeed a lot of us know. I suppose it even goes back to Mr Hope's point about the number of people who might be able to tell one of us whether we were an alcoholic being a judgement call.

I guess what those groups are struggling with is that under the current situation they can go ahead and do that kind of thing, but now their sense is, or they are being advised: "You might be liable. Somebody could take you to court."

I think what Mr Callahan has mentioned is that maybe there is a way of wording that which re-emphasizes some of the concepts in the charter, but how do you deal with the kind of comment that the physiotherapists have made, where they seem to have some kind of legal judgement, not that you are necessarily going to be caught on this but that you might be? It is that certain area of the nebulous that has them all frightened. Is it that we really cannot legally deal with that, other than to say we think the words that are there would protect them, or do you feel there is a very clear protection for them and their concern is simply not valid?

Ms Bohnen: I would say a couple of things. The suggestion that words such as "knowingly" or "wilfully" be added, which will be considered, would not be a response to what you heard from the physios, because they quite consciously and knowingly are making statements. They wish to have the law made very clear that those statements are acceptable statements.

In the tennis elbow example that was cited, it may be that they find particular difficulty, as do a number of other groups, with the word "dysfunction" which is in the controlled act, because they want comfort that they can assess. How can they be given this comfort? I guess governments and others can say, "Don't worry, don't worry," but that does not seem to be working. They are worried. So there can be amendments that make that clearer.

I have mentioned the word "dysfunction" because a number of groups, and I think on occasion physiotherapists, have said they find particular difficulty with "dysfunction" because that is the word which most accurately describes the result of an assessment. If you were focusing on that concern, you might say, "Maybe that word 'dysfunction' could go out there and it could be made clear that communicating assessments of dysfunctions is something that's okay."

Mr Beer: In that context, you made a comment earlier that instead of trying to define "diagnosis" more specifically, perhaps the key here is to look at how we define "assessment." At least that is what I thought you were leading to, that if there is some kind of amendment here that might be more helpful, it would be in looking at that term and having people more comfortable. As a layperson, you could almost use the terms "assessing" and "diagnosing" interchangeably, but I recognize that medically they have different meanings.

Is that a direction you could go, using Mr Wilson's point, go back to the earlier definitions that were used in the review and see if there is something that could be said around assessment that would not take away from the 13 controlled acts and what you were clearly trying to protect against, but would add a meaningful comfort level to those who seem to be wrestling with, "What is it I can really communicate after I have assessed somebody?"

Ms Bohnen: You also heard from the College of Nurses of Ontario this morning that it would be comfortable with something that incorporated the term "medical diagnosis." They understand that of course nurses assess their patients and come up with nursing plans as a result of those assessments, and they do not want to do medical diagnosis.

It may be that a combination of words that explains what "assessment" means and therefore what can be done, coupled with perhaps a more comforting definition of "diagnosis," would improve things for many groups.

Mr Beer: Is that something that, realistically, you within the ministry are actively looking at?

Ms Bohnen: Within the ministry we are actively looking at whatever options, frankly, are proposed by interest groups. You heard the minister say she really wants to hear from the committee, especially after consumer groups have a chance to speak, because they have spoken the least about this issue. What do consumers feel about it?

1410

Mr Burrows: I would like to add to that. When one considers the number of bills here and the number of clauses and the number of real issues other than profession-specific issues, there are not very many. But the minister yesterday made it quite clear that this has been a real problem. Linda technically has explained how it has evolved. I think it is safe to say we are not convinced that the wording is perfect. In fact, it appears obvious from the number of different points of view on this that the likelihood of something changing here is strong.

Hopefully, the presenters who come forward during the next few weeks will bring forward not only criticisms but some suggestions as to how these issues may be resolved.

Some of the options you have mentioned we definitely have considered: just saying "medical diagnosis," for example, and leaving it up to the courts; dropping a word here or there—"dysfunction" seems to be particularly problematic. There is a range of other options we have either thought of ourselves or had brought forward, but certainly we are not in a position to make any conclusive recommendations yet on what any change might be until we have heard, and hopefully someone will come up with a balance that is even closer to perfection than this refined version we have. I know from discussions with the minister, and you heard her say yesterday, that she is hoping sincerely that some very positive input will be received in this process on this particular issue.

Mr White: I would like to explore this issue of diagnosis and assessment as well. The explication you gave in terms of the history of the phrase "diagnosis," the origin in terms of western thought—one can follow that through literally thousands of years. It is a very troublesome issue. It is troublesome to many of the professional groups involved; it is troublesome in terms of defining or limiting what is something one profession can do that another cannot ever. The grey areas are particularly large.

You mentioned, for example, the systemic approach, which seems in the last generation perhaps, the last 20 or 30 years, to have evolved very strongly, but within the systemic approach you are really not talking about diagnosis as being a separate function but rather as being part of an ongoing process where a diagnosis or assessment whichever you want to use to refer to it, is continually refined. A function like diagnosis is not end product—it is not something you go to a particular professional for—but rather it is part of a treatment process that is really quite inseparable.

As that is the case, as we are looking at more and more team approaches, more systemic approaches, the issue of what a diagnosis is and defining it and eliminating it in a certain way becomes, I would suggest, somewhat problematical.

You mentioned the assessment diagnosis of various psychiatric disorders. In my past experience, I could quite easily define a client I saw as having suffered from childhood sexual abuse, or having a range of behaviours and identify that. I could quite easily see, for example, something as simple as a reactive depression: You are out of work; you have a reactive depression. These are not very difficult nor really very medical issues. I guess the difficulty I have is that in some ways we have a systemic and a very specific, limited derivation occurring at the same time. I think that creates a confusion. Unless we were to also, in defining diagnosis, specifically limit it to what might be organic or physiological within a specific realm, it becomes very problematical for that whole range of professionals.

Ms Bohnen: One suggestion which has been made is that this should be limited to diagnosis of physical conditions. But before recommending that I am sure you would want to hear from the Ontario Psychological Association, the Ontario Medical Association and a number of other groups whose particular expertise lies in the area of men-

tal illness, because there are differences of opinion as to what level of practitioner ought to be making diagnostic statements about psychological and psychiatric conditions. There is no easy answer to the issue you raise. Different groups have different views on the matter.

Ms Haeck: Just a quick question. It follows up on some of the things that have been discussed this afternoon. The nurses put forward a comment this morning about the holistic treatment of the patient. More and more there has been this move to not just deal with someone as the organic disease lying in the bed, but to look at the complete patient and have the history of the family and all the contributing factors as to what has brought about this disease, disorder, dysfunction and why that person may find himself in hospital.

We are all grappling with this can of worms: the question of diagnosis and how this impacts on these groups, of whether we are talking strictly in a hospital setting, and the whole definition of what health care is. I am looking to you as someone who has worked at this for four years and who has obviously heard these various questions many times and how you have come to grips with it. Each time I feel I have a handle on it, the target moves. Each group is presenting an interesting perspective and one to which I do not necessarily have an easy answer. From the ministry point of view, would you feel more comfortable if the courts defined health care?

Ms Bohnen: I do not have a difficulty with the lack of a definition of health care or health care service. It seemed fairly obvious to me that health care included all of the scopes of practice of the regulated professions and then some, and that if it ever became an issue a court would not have much difficulty figuring out what it meant in a concrete fact situation. On the other hand, it probably would not be very difficult to draft an inclusive definition in the bill that provided some guidance as to what health care services meant. That would not really be very difficult to do.

We are glad to hear you say that just when you think you have a handle on it, the target moves, because that is what it has been like for us. I guess our hope and the minister's hope is that through the course of these hearings, as you hear from groups and you ask groups if they have a proposal that would remedy the situation at least as far as they are concerned and hopefully as far as other folks are concerned too, that out of that the best approach will emerge. It may be one that will still leave some anxiety, but some public education and experience with the system will allay that.

Remember, diagnosis is something within the scope of practice of medicine now. The College of Physicians and Surgeons, in enforcing its licence to practice, has on occasion prosecuted non-physician practitioners who have been diagnosing their patients. We have not suddenly invented a new social issue here. It has been one that we have been coping with, applying common sense and experience to all these years, and we have just been having some difficulty coming up with words that will apply that experience to this new regulatory model.

Mr Hope: You made a comment earlier saying that I cannot come up with a conclusion of an individual or a patient, cannot diagnose, but if I see all the symptoms and I see what is going on and I recommend that you go see a doctor and then the doctor turns around and says, "Okay, you've got to go back and see him. This is what your problem is," the communication between—whether it be the nurse, which seems to be the major issue in rural Ontario dealing with smaller hospitals. A nurse assesses an individual. You said the ability to communicate with a doctor is there, between medical and medical. If I pick up a phone and say, "Doc, this is what is going on with this individual. All signs are that his arm is hanging there, and naturally it is not attached, so it must be broken," the doctor says, "Okay, we'll fix it." That dialogue can happen is what you are telling me.

1420

Ms Bohnen: Oh, absolutely.

Mr Hope: I can go to the person and say, "Okay, your arm is hanging there," but I cannot tell him the arm is broken. I am just trying to put this all in perspective.

Ms Bohnen: Telling somebody that he has a broken arm is not telling him he has a disease or a disorder.

Mr Hope: A disorder of a joint.

Mrs Cunningham: It depends on where it is broken.

Mr Hope: I am sorry. I may be nitpicking at this, but I have just got to get a better understanding, because what we are trying to say is that instead of going to the doctor and the doctor then moving it into this field of health services that are out there, so that the OHIP ticket just does not keep ringing on us, we are now saying you can go visit these people but you cannot make—

Ms Bohnen: Look, let's be very clear about this. First of all, if you have a broken arm, you have to have your fracture set. The only person you can go to to have your fracture set is a physician. If you are going to a nurse or a dentist or whomever for something that only a physician can provide the service for, then I think you are in trouble to start.

If your problem is that there are nurses who have to function with more autonomy in the rural areas, because we do not have as many physicians on site in rural areas as we do in urban areas, our health care system has accommodated that from the beginning of time and is going to continue to accommodate that. We have telephones. We have consultations. We have standing orders. We have myriad devices in place to make sure that people get the attention they need, hopefully as quickly as they need it.

I do not believe that these words that you as the government have to struggle with to define what cannot be done by certain practitioners are going to put a stop to that. But as the government, what you have to do is come up with the appropriate words so that you do not have every Tom, Dick and Harry, or Jill or Jane, telling people what is wrong with them when they do not have the foggiest notion what is wrong with them, unless of course as the government you decide that is the appropriate way to go.

Mr Hope: "Foggiest notion" as being specialized in that area. Is that what you are talking about?

Ms Bohnen: No, "foggiest notion" as knowledgeable about what causes people's symptoms.

Mr Hope: I heard a comment over there which I will ignore, but for so many years we have left this open gate. We have not cleaned the legislation up. Now we are at a point where we are trying to clean it up because some people have had more freedom to move around the health care system. Now we are closing it up a bit and we are putting rules in place.

Ms Bohnen: No, no. We are doing the opposite, Mr Hope.

Mr Hope: Well, not what we are hearing out of here, we are not.

Ms Bohnen: I guess it depends on whom you are listening to. You are going to hear from groups, like the College of Physicians and Surgeons, that are going to tell you this legislation is going to make Ontario the North American haven for quacks—at least that is what they have been saying for the past few years—because this is so deregulating the provision of health care that every quack is going to come here to practise. Then you are hearing from other groups which say, "We're not going to be able to do anything under this legislation because of this diagnosis controlled act."

It seems to me, when you hear both of these extremes, the truth is probably somewhere in the middle. As you heard the minister say, she acknowledges that there is probably going to have to be some fine-tuning to this provision. I think what what you are here for is to listen to a lot of community groups, including consumers, to help you figure out what kind of amendment would do the trick.

The Chair: Without a further question, would you like to proceed with the presentation.

Mr Burrows: Before Linda proceeds, I would like to apologize for the coughing. As a pharmacist, my assessment is that it is due to allergies.

The Chair: Do you need a medical diagnosis?

Ms Bohnen: I would like to quickly turn to the harm clause, which is tab M, because there have been some questions about that and some interest in it.

The harm clause that you see on the page before you is the version that appeared in Striking a New Balance. It in fact was the second draft of a harm clause. Unfortunately, I do not have the text of that with me. It is in the red book we gave to the clerk. I do not think you need to look at it, in any event, but suffice it to say that the original version of this clause was considered by groups like the College of Physicians and Surgeons as not being tough enough to deter unregulated practitioners. That college was of the view that the controlled acts were not of themselves sufficient to deter unqualified practitioners and to protect the public from harm from insufficiently qualified practitioners, so we had to have a kind of safety net clause, and that was the harm clause. As a result of the representations from the College of Physicians and Surgeons and some

groups that the first version was not tough enough, this version that you see before you was drafted.

After Striking a New Balance was widely circulated, groups such as the Coalition of Unregulated Practitioners, social workers and other unregulated groups—primarily those functioning in the counselling and mental health sphere—became very concerned that this clause would so chill their activities and put them in such fear of prosecution that they would be unable to function. You will probably remember that in response to their concerns, the previous government tabled the bill without this clause, but said it was the government's intention to reinstate it after there was further consultation about what it would say. The present government has concluded that the clause is unnecessary.

The most recent public discussion of the clause makes me think that certainly the Coalition of Unregulated Practitioners and other groups that support the coalition's position feel that it would be impossible to draft a clause that would not have undue effects on their ability to practise. They have no confidence at all that it is possible to draft one that would protect the public without making it impossible for them to practice.

I suspect that you will be hearing from the College of Physicians and Surgeons and perhaps some other groups that they would like to have the clause reinstated, and a very tough clause indeed.

It certainly does appear that there is not much common ground between those two extremes of the continuum on what the content of a clause would be, in any event, but as you heard from the minister yesterday, she is yet to be persuaded that it is necessary.

Mr Beer: Is it fair to say then in relation to the harm clause, if we go back to the 13 controlled acts, when we look at that in section 26, and this sort of is the link with what we just went through with diagnosis and assessment, the problem is really around paragraph 26(2)1, the communicating?

Ms Bohnen: Yes.

Mr Beer: The others, it seems to me, are clear. When you read them, one has a sense of what they are about. In the reviews in Alan Schwartz's report, why did they feel there was a need for a harm clause? I just cannot remember. Did he look at some of the problems that have come up? Were those addressed before his working group but he still came to the conclusion that there was a need for something, or in a sense have we moved on and are dealing with different issues?

1430

Ms Bohnen: There is some commentary in here that I think answers your question. He said:

"In commenting on the review's licence acts model, a number of participants expressed concern that licensing a series of acts identified as posing significant risk might of itself be insufficient to protect the public from harm. There are several reasons for this. The list, however carefully written, might inadvertently omit hazardous activity. The legislation might not keep pace with the development of hazardous new technologies that do not fit into one of the listed

categories. Harm might be done by unscrupulous, unregulated practitioners providing care that avoids transgressing any particular licensed act. This section is aimed at preventing harm resulting from treatment or advice provided by persons who are not members of regulated health professions or who, if they are, exceed their scope of practice or licensed acts."

The rest of it is not too relevant.

This section has been revised substantially from the June 1988 proposal in response to participants' concerns. The word "significant," which modified "harm" in that proposal, has been deleted, as has the "exception for a person exercising reasonable knowledge, skill and care." An inclusive definition of "harm", as set out in paragraph 3.

The metaphor that was used by the college of physicians was that the controlled acts were like fence posts but there was not any wire or string connecting them. The harm clause was proposed as that wire on the fence. To be fair, I think there was also a strong desire to persuade the college of physicians that the new licensed act model was enforceable and was in the public interest and the hope was that this harm clause would persuade them to support the model. That really did not happen.

Alan Schwartz will be here, I am sure, later on. You may want to ask him yourself his views about this matter.

Mr Burrows: If I can just add to what Linda said too, over the change of governments we found ourselves in the position of going out for consultation on this very issue. The feedback we received—which, by the way, is public knowledge and again is in the Ministry of Health library—was that there was no consensus. There seemed to be a very strong criticism of (a) the need and (b) the existing wording, which led the government to its conclusion not to reinsert the clause. I am sure you are going to hear this. Those individuals or groups that still feel strongly about this, I am sure, are going to make you aware of their concerns one way or the other.

Mr Callahan: Just to carry that forward, this is really way out, and I do not mean to offend anybody by it, but let's say you had a herbalist. We have just seen a very newsworthy tragic event. Let's say someone tried to bring that under treating a person by spiritual means. Let's say they believed that treatment by herbs was something better than normal treatment. Without a harm clause in there, someone could legitimately avoid breaching section 26 by trying to bring himself within that.

Ms Bohnen: I would not combine exceptions to the controlled act with the harm clause discussion, because the herbalist, for example, might provide advice without even purporting to provide a diagnosis. You would not necessarily be into looking for exceptions to controlled acts.

If you are asking, absent a harm clause, could a herbalist who does not perform any one of the controlled acts be prosecuted under this legislation, without a harm clause, the answer is no, he could not.

Mr Callahan: That is what I am concerned about. If you do not have that harm clause in there, precisely the things, I guess, the medical profession was concerned about would be a possibility.

Ms Bohnen: Remember, first of all, that the herbalist, or whoever else, is functioning in today's environment where the regulation is based on policing the scope of practice of medicine and, as far as we know, herbalists are not being prosecuted for that. So we do not seem to be changing much of an ongoing situation.

I think the issue might be viewed in terms of when adults choose to obtain advice from a variety of practitioners, be they herbalists, physicians, registered dietitians or whatever, that they make those choices for themselves. Even if accepting the advice causes them harm, under these bills, as long as no controlled act is performed, the government accepts that risk of harm as being consistent with a model based on freedom of choice, public education and personal responsibility.

Mr Callahan: Are you saying that if someone communicated to an individual or her personal representative a conclusion identifying a disorder, and was carrying out a controlled act in that regard rather than, let's say, taking a known medication or blood, I guess, that person would escape any responsibility?

Ms Bohnen: No. I am saying if they contravened that controlled act they would be prosecuted for that, if they provided no diagnosis and no explanation whatsoever as to what the cause of the person's symptoms were but simply gave out advice not coupled with the diagnostic statement at all. I thought that is what you were asking me.

Mr Callahan: No.

Ms Bohnen: Okay, I am sorry. It does not matter what their advice is. If they perform this controlled act, they could be prosecuted.

The Chair: Linda, you have just made a statement that they could be prosecuted. Under this legislation, how would a prosecution commence?

Ms Bohnen: All right. Remember, the scheme of this legislation, like the Health Disciplines Act, first of all places the responsibility for enforcement on the colleges. Police do not lay charges; crown attorneys do not lay charges or prosecute under the existing legislation. It is a college responsibility. In fact, the experience we have with the Health Disciplines Act and other statutes demonstrates that for the most part they only act on the basis of the complaint, and the complaint is generally made when harm has been done or there is a real likelihood of harm being done. You might recall, from one of the papers you saw yesterday, that really how the system works today is that the colleges only go after and prosecute on a complaint basis instances of likelihood or real harm that happen to violate one of their exclusive scopes of practice.

We are not talking about this becoming a provincial offence, being prosecuted with the frequency of the Highway Traffic Act. That is not how it works. We do not have health police like the OPP patrolling these things and we do not want them, I do not think.

The Chair: It is almost 2:40 and we are ready for our next delegation. I have two comments, one from Mr Beer and one from Mr Owens.

Mr Beer: On these two issues, this has been very helpful both in clarifying some things and perhaps obscuring some elements as well, which is not your fault. Is it understood that you might want to come back with our two witnesses again later on?

The Chair: If that is the wish of the committee.

Mr Owens: This is exactly what my comment was to be directed to. Because of the issues around diagnosis and harm, we probably do want to have a more full discussion, before we get too far into the proceedings, so maybe early next week, if our schedule allows us to do that.

The Chair: I suggest that as we find there are changes in the schedule and cancellations—I know both Ms Bohnen and Mr Burrows will be here. We can call on them as we have space available and will make the space available through direction to the clerk to allow for this to fill the time available. Is that the wish of the committee?

Mr Owens: The other thing we may consider doing is taking some time before or after the hearings; perhaps before would be better, say meeting at 9 o'clock for an hour, an hour and a half before we have hearings.

The Chair: The suggestion from the clerk is that we can wait until Monday to make that decision. We will have a better idea of what the schedule looks like at that time. I also point out to the committee that although the minister is going to be away, Mr Schwartz is coming in on the September 16. After having heard from everybody, we would and could have additional time then, some significant time, perhaps a day or two if you wish, to discuss these issues again. I just point out that is an option that available and perhaps we could discuss this Monday.

1440

Ms Bohnen: I just remembered there were also some tabs dealing with title protection and a couple of other issues that I did not get to. I am sorry about that, but whenever it is convenient for you we could review those.

The Chair: We will attempt to schedule in time. We will know by Monday what is available over the next week in order to continue the ministry presentation, which we will note today is not yet complete. We have also noted the desire of members to have further discussion on the issues we discussed today. I am sure there will be other issues that will emerge from this as time goes by.

Mrs Cunningham: I have a question with regard to process. It has differed from committee to committee that I have sat on over the years. I am wondering whom the government will have with regard to clarifications and expertise on an ongoing basis. I ask the question with this in view: Many times we have witnesses come before us who are unclear or who go away with the wrong perception. Sometimes we can interject, but often we just cannot. I think it is wrong to have them leave like that. There were two this morning I could use as examples, but I choose not to at this time. They were left with the wrong impression. Sometimes we are able to clarify and sometimes we are not. Who will be the expert here? Madam Chairman, as the former minister you are very much aware that there were

always people from the ministry to answer our questions and witnesses' on an ongoing basis.

The Chair: I discussed this matter with the clerk. The information I have is committee protocol. It requires either the minister or the parliamentary assistant to carry the legislation through committee. In the absence of that, in normal committee protocol, either the committee members can address questions informally to ministry staff who are here and ask for responses in writing, hopefully the same day or at the earliest opportunity, or when the minister is here ask for clarifications at that time, or when we have the discussion following the hearings or with Mr Schwartz, and so forth, we can have those clarifications put on the record.

Mrs Cunningham: Are Mr Burrows and Ms Bohnen going to be here on an ongoing basis? Is that the plan?

The Chair: It is my understanding that both Mr Burrows and Ms Bohnen will be with the committee for all the hearings. Is that correct?

Ms Bohnen: Yes, but it is also my understanding from yourself, Madam Chairman, and from the clerk that we will be here but that we are not in a position to speak during hearings.

Mrs Cunningham: Unless we ask.

The Chair: The protocol of the committee is that when groups and witnesses are appearing, the questioning is between the committee members and the witnesses. If there is a request for clarification, that is done informally with the ministry. They submit that in writing to the committee or at another time, unless the minister or parliamentary assistant are here in which case they are the ones you direct the question to. That is committee procedure as it has been explained to me by the clerk.

Mr Owens: My understanding is that there should be a parliamentary assistant on board within the next day or so who will be available for questions.

Mr Callahan: Who is it?

Mrs Cunningham: I am sure we will have all his time and his expertise. A question goes to the parliamentary assistant, and if that person cannot answer it, then it is referred to staff. That has certainly been my experience.

The Chair: That is normal procedure as well. If the parliamentary assistant is carrying the legislation, he or she can ask the staff to give an explanation.

Mr Owens: That person should be here tomorrow; if not, by next Monday at the very latest.

Mrs Cunningham: I suggest it would be better, given the presentations so far. Good for you, Steve, because you just might get stuck if it does not happen.

PROFESSIONAL ADVISORY COUNCIL OF THE SPEECH FOUNDATION OF ONTARIO

The Chair: We have a deputation waiting. I would like to call the Professional Advisory Council of the Speech Foundation of Ontario. Please introduce yourself. Welcome to the social development committee. You have 40 minutes for your presentation. I ask that you try to leave some time for questions from the committee, if you wish.

Mr Girolametto: Sure. I am going to be really brief. In fact, I would rather have my hair cut with a chainsaw than be here today with this weather outside. At home I have two contractors let loose in the house, a heating contractor and a building contractor, and half of me wants to be there to supervise and the other half is very grateful for the chance to be here to speak with you.

My name is Luigi Girolametto. I am a speech-language pathologist at the Hospital for Sick Children and assistant professor at the University of Toronto in the graduate department of speech pathology. I am making this presentation on behalf of the Professional Advisory Council of the Speech Foundation of Ontario. That title and address are on the cover page of your handout, which is pink.

When I saw the advertisement in the *Globe and Mail* inviting presentations to the standing committee, I phoned Lynn Mellor. When I got the appointment, I immediately panicked. Lynn gave me political science 101 over the phone really fast. I did not know what to expect, so I prepared a presentation and hope I will be brief and that the concerns I have chosen to present today will be accepted by the committee.

I know a lot of work has gone into this bill. By and large it is a very favourable bill. It has certainly gone through successive governments, and we have a chance at this point to make it an outstanding bill.

I will just quickly go through the handouts with you so that you know what is in your package, and then I will start from the beginning. Page 2 has a brief description of the goals of the Speech Foundation of Ontario and the aims of the professional advisory council. I will look at those with you in just a moment. It is a bit of information about the group. Page 3 is a summary of the two recommendations I want to suggest today. Pages 4 and 5 are the concerns I want to present to you, so I will go over those in quite some detail. Finally there is a lot of information in the appendix that I will be referring to. There are some sample doctorate degrees I will refer to later. There is a sample appointment letter to parents at the Hospital for Sick Children whose children are receiving a developmental evaluation. There is a members' list for the professional advisory council, of which I am the chair, and a members' list of the board of directors of the Speech Foundation of Ontario. Finally, there is a position statement of the Speech Foundation of Ontario, and that is all happy reading for you some time when you cannot sleep, I guess.

To go back to the beginning, the Speech Foundation of Ontario has as its objectives to promote a wide variety of clinical programs to deal with speech and language disorders. Also, it supports treatment, research and the training of speech-language pathologists at the master's level. It also promotes and advances public awareness.

The aim of the professional advisory council is to advise the board of directors, none of whom are speech-language pathologists, about research issues, training issues and service issues to children with speech and language disorders.

On page 3, the two recommendations I am going to make today are summarized for you. The first deals with controlled acts. I gather you have heard quite an awful lot

about controlled acts today. Linda Bohnen, who just spoke, brought this up as well. As it reads now, all communications with regard to speech-language assessment and speech and language disorders would have to be made through a doctor or a psychologist. We would ask committee members to review this clause to allow speech-language pathologists to communicate the results of a speech and language assessment directly to the patient; that is, to make a speech and language diagnostic statement to the patient himself or herself.

The second recommendation deals with section 30, the restriction of the title "doctor." As it reads now, a speech-language pathologist with a PhD would not be allowed to use the title "doctor" in the provision of health care, whereas a psychologist with the same degree status would be allowed to use the title "doctor." We ask the committee members to recommend expansion of the title "doctor" to those health care professions offering doctorate programs.

1450

I will quickly go over some information about controlled acts. In general practice today, speech-language pathologists routinely present conclusions to the patient, or to the patient's family in the case of children and stroke victims, and counsel them regarding the results of the assessment. This is routinely part of the assessment process. Speech-language pathologists are highly trained to assess, diagnose and treat a very specific group of speech and language disorders and dysfunctions, as set out in their scope of practice. They are also trained to recognize when it is appropriate to refer the patient to a physician for an assessment.

The problem we see with this section as it stands now is that the physician or psychologist does not perform the assessment and is not present during the assessment. Thus that person who communicates the result of the assessment does not know the tests used, the behaviours the child or patient presented and how the patient presented in general. That person is not specifically trained in the assessment of all communication disorders.

As an example, 60% of the referrals that come to the Hospital for Sick Children by physicians are for articulation disorders. Of those, only about 20% are articulation disorders. In fact the rest are speech and language disorders with a primary language component. So doctors by and large are not that aware of the range of speech and language disorders that children can have.

These persons are not involved in the design of treatment programs based on assessment results, cannot make prognostic statements on behalf of patients and may not be involved in the long-term treatment of the patient's communication disorder. Therefore, as the diagnosis evolves—this happens very frequently, that a child with a language disorder evolves into a child with an articulation disorder once the language clears up—a further visit to a doctor would be required to clarify the diagnosis or update the diagnosis.

The gist of all this is that for the patient it means an unnecessary number of visits. First there is the assessment by the speech-language pathologist, a visit to a physician or a psychologist for the conclusion, then back to the

speech-language pathologist for further treatment. Pages 2 and 3 of the appendix, which is the position statement, further clarify this, and I will just let you read that on your own. You might just want to note that pages 2 and 3 do in fact clarify this further.

There is a lot of confusion, I think, that could be generated to the patients. Specifically, there is some concern that complete information will not be shared with the patient or the patient's family from those most knowledgeable and qualified in the area of communication disorders. That can result in confusion to the patient, particularly when, as I mentioned earlier, most physicians are referring for articulation disorders and do not realize that they are in fact referring a child with a language impairment or a language delay.

Finally, there is the delay of treatment as well. Because of the issue of having to go to the physician or psychologist for communication of a diagnosis and back again, there is a potential delay of treatment. For the health care system, this all adds up to extra dollars.

We would therefore ask that committee members review this clause and allow speech-language pathologists to communicate the results of an assessment directly to the patient pertaining to speech and language.

The second issue, on page 5, deals with section 30. I am racing through this, but probably you were able to follow that part and I will be happy to answer questions at the end of the presentation. Historically, speech-language pathologists holding doctorates, ie, a doctor of philosophy—I have three sample degrees in the appendix for you; those are degrees of persons who are on the professional advisory council currently; there are five speech-language pathologists with doctorates on the professional advisory council at present—worked in academic and research settings. In the last 15 or 20 years, however, there has been an increasing trend for PhDs to be employed in health care settings. Their positions have combined clinical excellence in their specific area of speech and language pathology together with clinical research. The use of the title "doctor" by those who have earned this degree is common practice in health care settings in all the other Canadian provinces, in the United States, England, Australia and the rest of Europe.

Problems that arise from restricting the title "doctor" deal, first of all, with an issue of inequity. Psychologists with the same degree status, that is, doctor of philosophy, will be allowed by this act to use the title "doctor," and I ask, what makes the speech-language pathologist with that same degree status so different? Second, I think there is a potential for confusion to the patient in the sense that a patient who visits a psychologist can call that psychologist "doctor," yet when that patient subsequently visits a speech-language pathologist, he or she reverts to Mr, Ms or Mrs.

As an example, if you will flip to the appendix, there is a sample appointment letter. This is an appointment letter that is sent out by the developmental evaluation unit. If you look at Tuesday, May 28—by the way, this is a patient I saw in May—at 10 o'clock, that patient had a psychology assessment with Dr Marcovitch, psychologist. She has a

PhD and the patient's family was able to call Sharon Marcovitch "doctor." On Wednesday at 9:30 there was a speech and language assessment with me in the speech-language pathology department. If this act goes through, the parents of that patient would be required to call me Mr, yet I would have the same degree qualifications up on the wall. I think this inequity creates confusion, and also for the consumer, and I think consumers have the right to know the degree status of the persons whose care they are under. I think that in knowing this, it alleviates some of the confusion titles can create.

The right to confer a degree is vested in institutions of higher learning. Excluding PhDs from using the title "doctor" infringes on the role of universities as well as the individual rights of the degree holder. Again, I emphasize that this does go against standard practice in North America and Europe.

Finally we would ask the committee members to recommend expansion of the use of the title "doctor" to those health care professions offering doctorate programs. This involves nursing, occupational therapy, physical therapy and audiology as well as speech-language pathology.

That is it. I have kept it short and I am very happy to answer any questions you have.

Mr Beer: I want to address my question to the last point you raised around title. It is for purposes of clarification, but I think is important. We have been visited by a number of your colleagues, broadly speaking, on this issue, but the point is not that everyone who is a speech pathologist can refer to himself or herself as "doctor," but only those who have fulfilled the requirements of a doctoral program at a university.

Mr Girolametto: Exactly.

Mr Beer: Those people are in the same boat as somebody who did it in history or philosophy or whatever; they have a right to use that term "doctor" and should continue to have that right. I take from that, first of all, there is the principle about it. I think there was a gentleman this morning who wondered whether, even if the province sought to deny you the right to use that, in point of fact that would stand up in a court of law in any event. But it would seem to me there is a point of principle there that we have to look at, and frankly I had not been aware of that particular part of the problem.

I have also been told that in a hospital setting, if you are going around with your coat on, it would say Dr So-and-so and then underneath it says what you do. So in terms of confusing patients, it is quite clear that you are a speech pathologist or whatever.

Then I guess the other point that has been made is that there are a number of people within the greater Metropolitan Toronto area—one example given to me, I believe, is the person who is the head of the Hugh MacMillan Medical Centre, who is Dr So-and-so but whose degree is in engineering, albeit, as he has gone through his career, he has applied the engineering to helping those with disability problems and so on.

That is, as I understand it, the nature of the problem.

I think for me, and what I have said to people who have come in, I want to explore both with ministry staff and whoever else out there thinks you should not be allowed to do that what the reason or reasons are, because on the face of it, it is a hard one to accept when it would appear that other jurisdictions allow somebody who legitimately has a doctorate to call himself doctor. That is where I am with that one. It seems to me you have raised a legitimate point. On the face of it, it would seem perhaps we are moving into an area that we really do not need to move into, subject to somebody explaining to me that there is some compelling reason why we have to ensure that you cannot call yourself "doctor," at least not in a hospital.

Mr Girolametto: I think too that speech-language pathologists and audiologists will have a college which will ensure that this title is used appropriately by those persons possessing the degree status. I think too that the legislation does promote some inequity. A psychologist, as I pointed out, will be allowed to use that title, and I think it is either all or nothing with respect to health care providers.

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Mr White: Further on with what Mr Beer was mentioning, it strikes me that with that exclusion as it is written into the bill, you could still refer to yourself as a doctor. Most likely you would not be called to account. You probably would not be charged under the act. Most of those things would not happen.

On the other hand, within the institution where you work, although your patients would not be confused about what your role would be, that institution would not recognize your doctorate. As you suggested, this patient would have an appointment with Mr Luigi but it would not say "doctor." The institution would not recognize it.

Mr Girolametto: That is right.

Mr White: Following Mr Beer's point, if one has a doctorate in the area of his specialty, whether it is social work, speech pathology or whatever, that does not seem to be problematic unless one is, say, working as a speech-language pathologist and has a doctorate in—

Mr Girolametto: Engineering, math, history.

Mr White: Right. In that sense it would be misleading, but I cannot see otherwise that it would be.

Mrs Cunningham: This is one of those instances where I thought we had asked this question yesterday of the staff and had been assured that in fact his title, PhD, could be used and people could be referred to as positions. If it is appropriate, Madam Chairman, I think that should be reiterated.

The Chair: We will make note of that and at the appropriate time—a comment?

Mr Cordiano: I think there is a distinction to be made. It is not just the title PhD; I think it is the title "doctor" that we were talking about, the actual word "doctor" being used in front of someone's name.

The Chair: There will be an opportunity for further discussion of many of these issues at the appropriate time

during the hearings, and we heard there is likely going to be a PA appointed in the next little bit of time.

Mr Cordiano: Okay, but I just wanted to make that distinction as far as I was concerned, that there is quite a distinction between what you have just said, Mrs Cunningham, and what I think the deputant is saying about the title "doctor," that it is something vastly different.

Mr Girolametto: Yes. The D in PhD stands for "doctor," but the restriction of the use as presented by the bill restricts us from using that specific word.

Mrs Cunningham: My point was that when I asked the question yesterday, the response I got was that the word "doctor" could be used. I would suggest, sitting here as a person who has been involved with the medical community, that anybody who has a PhD who wants to be called doctor, unless some institution says otherwise—if that were me and I had your degree, I would not work for them. It is that simple.

ONTARIO SOCIETY OF MEDICAL TECHNOLOGISTS

The Chair: The next group appearing before the committee is the Ontario Society of Medical Technologists. Would you please come forward. You have 20 minutes for your presentation. Please introduce yourselves to the committee. We would ask that you try and leave some time for questions at the end of your presentation.

I would ask all members to give you their attention and ask you to introduce yourselves and make your presentation.

Mr Morrow: My name is Des Morrow. I am pleased to be here as president of the Ontario Society of Medical Technologists and to have the opportunity to speak today in support of the Regulated Health Professions Act.

The medical laboratory technologists of Ontario have long pursued the goal of self-regulation and inclusion in the Health Disciplines Act. Over the past 10 years considerable changes have taken place in technology, the technologists and the laboratory environment. Public awareness has increased and enhanced the need for legislation to protect the public interest.

The Ontario Society of Medical Technologists has been an active participant throughout the Health Professions Legislation Review, monitoring and commenting on the respective stages. This dialogue with the review team and later with the professional relations branch of the Ministry of Health has resulted in legislation which meets the need to provide protection for the public and which represents the profession appropriately.

The OSMT represents some 8,000 medical laboratory technologists working in the province, who in turn constitute the third-largest group of health care professionals in the province. The practice of medical technology includes the main disciplines of clinical chemistry, clinical microbiology, haematology, immunohaematology, transfusion medicine, histotechnology, diagnostic cytology and the disciplines of virology, parasitology, immunology, cytogenetics and electronic microscopy; quite a mouthful.

Mr Beer: Is there going to be a test at the end?

Mr Morrow: That is why I have them written down. I cannot remember them.

In clinical chemistry, technologists analyse blood specimens to measure a wide variety of constituents, ranging from a simple blood sugar level in a comatose diabetic to the complex analysis of drugs and hormones. Examples of this might be the identification of the causative drugs in an overdose patient or the investigation of the causes of infertility. This is often accomplished using highly sophisticated and computerized equipment. In haematology, the blood cells and plasma are studied in search of anaemias, leukemias and clotting disorders such as haemophilia. Clinical microbiology encompasses the isolation, identification and antibiotic susceptibility of bacterial, fungal and parasitic infections. In more simple terms, it perhaps might be the identification of a bacteria causing an infected throat and indicating which antibiotic would be effective in treatment.

The importance of compatibility testing for units of blood to be transfused during surgery or following blood loss and the cytological assessment of pap smears for the early detection of cancer is self-evident.

Medical laboratory technology therefore plays a vital role in the diagnosis, treatment and prevention of disease, and as such it is imperative that the consumer is protected from incompetence and has a say in the performance and future development of professional practice. Quality assurance of laboratory testing was part of our daily professional life long before the concept was generally accepted and we support the professional quality assurance aspect of this legislation. We are pleased that the college council will set clear standards for entry to practice and that the act embodies the concept of professional equality.

I would like to pass the floor to my colleague Sheila Woodcock, who has chaired the OSMT legislation steering committee, to comment on the history of the OSMT involvement and more specifically on Bill 53, regulating the profession of medical laboratory technology.

1510

Mrs Woodcock: The Medical Laboratory Technology Act will establish a College of Medical Laboratory Technologists of Ontario, which in turn will set standards for entry to and ongoing practice in medical laboratory technology.

Even prior to the initiation of the Health Professions Legislation Review the OSMT had been actively pursuing legislation for the regulation of our profession. The Laboratory and Specimen Collection Centre Licensing Act exists to regulate the operation of medical laboratories, but reference to the technologists is limited to a broad definition of who may work as a technologist. It does, however, define the role of the laboratory technologist as one who performs tasks which require the exercise of independent judgement. This is distinct from the technician, who works under direct supervision and performs only tests which require limited technical skill.

Changing technology has simplified the performance of some of the more frequently performed tests, such as blood glucose. Many diabetic patients use glucometers to monitor their glucose level and adjust the insulin dosage if required. Within the hospital setting, the use of glucometers has proliferated. The apparent simplicity of this instrumentation may lead to the misconception that

checks and balances used in laboratory testing are not required. This is not the case. In fact, quality control of the procedure is vitally important and there have been at least two tragic outcomes from the inappropriate use of glucometers.

An extensive study of current practices has been undertaken and recommendations developed for standardized implementation within the hospital under the jurisdiction of the laboratory. This has subsequently been endorsed by the Canadian Council for Health Care Facilities Accreditation.

The public needs to understand what happens in that mystical place, the laboratory, and the importance of the accuracy of the results produced. The Regulated Health Professions Act will not only create an increased awareness of the profession but also a means of investigating and obtaining information on individual practitioners. A member of the public will be able to approach the College of Medical Laboratory Technologists to verify the qualifications of an individual or to lay a complaint should that be necessary.

The days of the bubbling flasks, the big syringes and most manual techniques are long gone. The laboratory today is filled with sophisticated computerized equipment requiring the vigilant judgement of the medical technologist. Similarly the old images of the past are replaced by highly skilled modern medical laboratory technologists, vital members of the health care team.

The minister, in her proposed amendments tabled yesterday, has recommended a change in the wording of the statement describing the scope of practice of medical laboratory technology. It now reads: "The practice of medical laboratory technology is the performance of laboratory investigations on the human body or on specimens and the evaluation of the technical sufficiency of the investigations and their results."

Changing technology and the consequent need for change in the role of the technologist are reflected in the revision of the former wording, "on specimens taken from the human body." Some tests can now be performed using non-invasive techniques at the patient's bedside.

The medical laboratory technologist should be involved in near-patient testing to avoid pitfalls encountered previously with the indiscriminate use of new technology. The change in the scope statement does not limit the role of the technologist as the evolution progresses. This in turn should reassure the public of the appropriate skills being available no matter where the testing is performed.

Another change to the scope statement qualifies and clarifies the phrase "the evaluation of the technical sufficiency" with the addition of the words "of the investigations and their results."

The minister's proposed amendments also recommended inclusion of a controlled act permitting the medical laboratory technologist to obtain the blood samples required for testing. The minister has proposed the addition of a section 3.1 to Bill 53: "In the course of engaging in the practice of medical laboratory technology a member is authorized, subject to restrictions on his/her certificate of registration, to take blood samples from veins or by skin

pricking." As technologists we would recognize "skin pricking" as being capillary puncturing.

The public image of the laboratory technologist is often limited to the person taking the blood sample. As a profession, we have striven for years to overcome or at least broaden this limited perception. It is important, however, to recognize the potential hazards associated with the collection of blood and to put in place a mechanism for quality assurance of the procedure. With the inclusion of this controlled act in Bill 53, the College of Medical Laboratory Technologists will be responsible for setting and maintaining standards for blood collection.

Once this legislation has received third reading and royal assent, a transitional Council for Medical Laboratory Technology will be appointed. This council will have the task of writing the regulations to define the entry-to-practice requirements. We understand that grandfathering will be a concern to some of our profession and we propose to work with the transitional council on this issue, but in the course of the hearings it is entirely possible that this issue may be raised by other technologists.

We want to say that we support the minister's proposed amendments to the legislation.

Mr Morrow: We will be glad to answer any questions we can.

Mr Owens: It is funny you should raise the issue of grandfathering. This is a concern that has been raised to me by a number of my former colleagues down the street at the Toronto General Hospital. I wonder if you could briefly explain to the committee what is meant by grandfathering and why some people find that problematic.

Mrs Woodcock: What is meant by grandfathering is that when you bring in new legislation that encompasses a profession there is sort of an underlying assumption that—the transitional council will have the task of defining what the entry-to-practice standards are, and there probably will be one standard defined. We know that standard within our profession would be certification by the Canadian Society of Laboratory Technologists, which is held by 90% of the practitioners in the province. There are, however, a small number of people who hold other qualifications, and the challenge facing the council will be to decide what are appropriate qualifications and whether or not those people will be accepted with their existing qualifications or whether they will be required to undertake further examinations, training, whatever.

As a society we had discussion on this and we will be in dialogue with the transitional council, but at this stage we feel it is not appropriate for it to be addressed, but we know there are concerns out there, yes.

Mr Callahan: That is just a little bit more than grandfathering. That is really retroactively possibly changing someone from fish to fowl.

Mrs Woodcock: That is one interpretation, that is true, yes.

Mr Callahan: You are saying it is about 5% of the present profession who would be affected by that.

Mrs Woodcock: Roughly; 5 to 10 per cent.

Mr Callahan: These would be people who would be at the point where they might be close to retirement.

Mr Morrow: These are probably people who are British or American qualified and presently can work under some complementary legislation, the laboratory licensing act, which defines who can practise medical technology in the province.

Mr Callahan: I speak only personally. I recognize the reasons for this legislation—very ambitious and also needed and very good—but I do have some concern about the fact that it is more than grandfathering. Grandfathering is, in some respects, where you put a time frame on legislation to have it disappear or not take effect or to take effect at some later date, but it does not, as far as I know, ever interfere with a person's right or ability to continue in the profession he has chosen.

That does concern me. I do not know whether the rest of the committee would want to know, but I would certainly want to have some idea if I were voting on this, which I will not be because I am only a sub, but I would want to know what hurdles these people might have to overcome to continue in the chosen field that they have. I do not know whether that can be done or not.

Mrs Woodcock: We cannot answer that question until the transitional council defines the entry-to-practice standards and makes the decision on what it will do with these people. They may very well decide to accept everybody who is currently practising as a technologist for registration within the college.

Mr Callahan: You are saying then that they have not given any consideration to that at this point and would not have something at least in mind before this legislation was passed.

Mrs Woodcock: As a society we have recommended that the qualification held by the majority of technologists be recognized as the entry-to-practice standard, but we have no way of knowing that this will be the only qualification accepted.

Mr Callahan: All right.

Mrs Woodcock: So it is very difficult to argue this whole issue until later on in the process.

The Chair: I would like to thank you for your presentation to the committee. I am sorry, we are out of time.

1520

ASSOCIATION OF ONTARIO MIDWIVES

The Chair: Our next presenter is the Association of Ontario Midwives.

Mr Callahan: These people get a badge for the most effective lobby that has ever existed in this province, and I want to be the first one to congratulate them. There probably were more petitions presented in the Legislature on this one issue than in the history of this country.

The Chair: Welcome to the standing committee on social development. You have 20 minutes for your presentation. We would ask that you leave a few minutes for questions.

Ms Kilpatrick: I think we will have lots of time. I saw in the agenda that I had 10 minutes, the one I saw earlier.

The Chair: Are you representing the Association of Ontario Midwives?

Ms Kilpatrick: Yes. Maybe my math is bad.

The Chair: Actually the agenda looks like 10 minutes, but the association should have 20 minutes. If you can do it in a shorter time, that will be fine.

Ms Kilpatrick: My plans were shorter, so hopefully we will get through it.

I am going to start by making some general comments about our association and our association's involvement with this process and general comments about the legislation. We have only a couple of specific comments to make specifically on Bill 56, the Midwifery Act.

Our association has participated in this legislative review since the review team was appointed in 1983. The lengthy consultative process has provided the opportunity for discussion among many professions regarding general health care and governance issues. We believe the resulting legislation will have a positive impact on the health care system, benefiting not only the public but the professions as well.

This legislation moves us towards a more responsive and accountable health care system. Open public hearings will help to ensure accountability of the professions to the public, and public protection will be enhanced by the increased number of public members participating on councils. The Health Professions Regulatory Advisory Council also provides for greater public input to health care policy decisions.

We also fully support the concept of providing health care consumers with a wider range of choices of practitioners. We believe the controlled acts model which controls those acts that are potentially harmful instead of licensing a profession, thus giving that profession a monopoly over all acts interpreted to be part of that profession, offers a balance of increased consumer choice and public protection. This framework acknowledges the important contributions of a variety of health care providers to the system.

Our association supports the Health Professions Regulatory Advisory Council also as a mechanism to keep the legislation and in turn the health care system responsive and to keep the act relevant.

We would like to make one comment on the procedural code and our other comments, as I stated, will be specific to Bill 56, the Midwifery Act. With respect to quality assurance programs in section 80 of Bill 43, confidentiality is addressed as it relates to the member. We believe it would also be appropriate to address client confidentiality when discussing quality assurance programs.

Midwives will be providing primary care to their clients during pregnancy, labour and the post-partum period, according to the proposed scope of practice. In addition to the draft amendments submitted by the Minister of Health to this committee, we would like to ask the committee to consider the following issues:

There are three other acts which we believe should be included to enable midwives to provide continuity of care within the proposed scope of practice and according to the international definition of a midwife adopted by the Interim Regulatory Council on Midwifery.

The first is pre-natal blood screening. This is performed on all women and we believe midwives should be permitted to draw blood in this instance. In addition, if the mother is Rh negative, a post-natal blood screening is also routine. The change that would be required is that midwives would be permitted to perform venipuncture for the purpose of routine blood screening. Another method of obtaining a blood sample is by skin pricking or, as we just heard, capillary puncturing. This is currently used by some midwives to obtain a haemoglobin assessment by use of a haemoglobinometer.

The second is that in the course of a normal labour it may be necessary to rehydrate a woman by use of intravenous fluids. This is an instance where a midwife would be continuing to provide primary care. In the interest of continuity, as well as in recognition of the midwife's role as primary care giver, we believe midwives should be able to insert an intravenous catheter for the purposes of rehydration.

The last is that with the recent draft amendment proposed to this committee we understand the suggestion is that midwives be able to prescribe as well as administer certain drugs as specified in regulation. We believe midwives need access to a limited list of drugs in a limited number of situations, and in each of these situations it is within the course of complete primary midwifery care and enhances continuity of care, as well as client safety.

Our concern relates exclusively to post-partum care when a midwife may need to leave a medication with a woman to take in the midwife's absence. Rural midwives are particularly concerned about this, as their clients may not be able to fill a prescription for several hours. It is our position that the inclusion of dispensing for specific medications in specific post-partum situations allows midwives to practise fully within their scope of practice and according to the definition adopted by the Interim Regulatory Council on Midwifery.

That is all and I am ready to answer questions.

Mr Johnson: Midwives are, in quotations, "a new profession," but they are not really; they have been around for a long time. At one time they were an accepted and welcome part of the community, I have no doubt. As you have given your brief today, you have asked for some things and you certainly have gone into some detail, but I was wondering how easily the kind of care that is advocated by midwives, client-centred and continuity of care, will mesh with our modern hospital routines. That is not to suggest that what midwives are doing is something ancient or something that is not new, but how will it mesh with routines in the hospital?

Ms Kilpatrick: Currently there are midwives who do not work within the hospital as a recognized part of the team. But there are clients who seek midwives who still want to have their birth take place within the hospital. So I think the system has begun to see how midwives practise

and what people want from midwives. Those of us who have worked with our clients within the system have begun to give it a try. I am not quite sure whether you want to know where we fit in relation to nurses and physicians, if that is the specific question you are asking.

Mr Johnson: Certainly you will have a relationship with them.

Ms Kilpatrick: Right.

Mr Johnson: I was wondering what kind of relationship you will have in working with nurses and doctors. What kind of relationship do you expect?

Ms Kilpatrick: Think of the midwife as the practitioner providing primary care, not just client-centred or continuity of care. We also have submissions at this point in time in the review of the Public Hospitals Act that midwives should have admitting and discharge privileges within the hospital system. So midwives would work with their client going into the hospital and providing primary care within the hospital system. We would interact with nurses, as nurses are providing the ongoing care within the hospital when the midwife is not with her client, if the labour is over, for instance, and the woman remains in hospital overnight. The midwife would not remain throughout the night, so the nursing staff would then be providing the ongoing care. The relationship we envision with physicians would be most commonly a consultative relationship in situations outside a midwife's scope of practice.

1530

Mr J. Wilson: To play devil's advocate, the Ontario Nurses' Association suggested today that perhaps midwives should be qualified nurses first. Do you want to comment on that?

Ms Kilpatrick: Yes, we have been commenting on that since we made our first submission to the Health Professions Legislation Review. One of the arguments we made at that point in time is that in fact the profession of midwifery is a longer-established profession than the profession of nursing. Midwifery is an identifiable profession with a very defined scope of practice, much more clearly defined than many others possibly, and the tradition of nurses first and midwives second is a very recent North American phenomenon.

In fact, when the Task Force on the Implementation of Midwifery in Ontario did its investigations worldwide, it found there actually were a lot of different countries with well-established professions of midwifery that identified it as a separate profession from nursing, not a specialty of nursing, as the ONA would describe it. That essentially was our position, that it is a separate profession traditionally, and it is a very recent phenomenon that we have this understanding that it is a specialty of nursing. It is primarily in North America that we have this understanding.

Mr J. Wilson: In a hospital setting, following on Mr Johnson's question, how do you figure you would get along with nurses, who seem to have their concerns? It seems like a bit of a turf battle, to tell you the honest-to-God truth.

Ms Kilpatrick: I think the only way we can find out how we will get along is by working alongside the professions that are in the health care system now. As Mr Johnson said, we are a new profession in Ontario and we will be establishing relationships with a number of professionals who have been working in the system as long as they can remember. It will be, I think, a slow integration process.

The task force on the implementation of midwifery asked hospitals and services to make presentations if they were interested in midwives working in their particular hospital. I think one of the ways will be midwives' services or midwifery services being offered by institutions or by centres that are interested in having midwives working there. So the beginning of establishing relationships with other professionals working in the system, primarily nurses and physicians, will first be with those who want to work with midwives. Then the rest of the system will become exposed to midwives working in those particular services of whatever sort: an exposure kind of process and a working out of the roles that midwives will play. How that will affect the roles of the other professionals will then be worked out basically in the working relationships.

Mr Owens: What types of medications would you be looking at prescribing?

Ms Kilpatrick: We have talked about this on the Interim Regulatory Council for Midwifery. They are just beginning to look at regulations. They would be very limited, mostly post-partum, possibly just analgesics for post-partum pain. There is an injection of an oxytocic drug that stops the woman from bleeding post-partum. There is another time that may be necessary: in a labour, the same kind of agent, an oxytocic agent, that would stimulate the labour. We have not made the recommendation that midwives would directly prescribe that, but post-partum you may need to give a woman an injection of an oxytocic drug to stop bleeding.

That is administering more. The prescribing was to cover, I believe, working within the hospital as well, so that you have the power to write an order and leave an order behind with a nurse.

Mr Owens: Basically, you are looking at a Tylenol 3 or something like that. We are not talking about any type of narcotic agents.

Ms Kilpatrick: Well, Tylenol 3 is considered a narcotic agent. Analgesics basically for pain relief post-partum are one of the main. There are very few actually. It is a very limited list of medications that midwives would need access to and would be using within a normal practice, within a low-risk pregnancy.

Mr J. Wilson: How many midwives are there currently in Ontario?

Ms Kilpatrick: Our association has a roster of practising midwives and then we have a membership for non-practising midwives. The practising midwife membership in our association is around 60. Our non-practising midwife membership is fairly low, around 25. There are probably thousands of trained midwives from numerous other countries.

The College of Nurses did a survey, around the same time that the task force on the implementation of midwifery was trying to sort out how many trained midwives there are from other countries, as well as the practising midwives, and the College of Nurses found out how many college registrants were also midwives. But there are a number of midwives, particularly from the Philippines and other European countries like Holland, who are direct-entry midwives, that is, they are not nursing. Therefore, right now they are probably not registered with any other health profession, college or association. There is really no way of assessing those numbers.

Mr Callahan: I have two questions. The first one is, apart from these people who have come from other countries, where does one become educated in midwifery?

Ms Kilpatrick: Currently?

Mr Callahan: Yes.

Ms Kilpatrick: In our association, our membership, the majority of practising midwives are apprentice-trained midwives. They learn from other midwives, usually here in Canada, many of them in Ontario. About one quarter of our membership are midwives who have formal midwifery education from another jurisdiction.

Mr Callahan: Is it proposed that this would be a course that one could take at one of the community colleges or a university?

Ms Kilpatrick: The decision has not been made where the midwifery educational program will be mounted from. There is no decision, as far as I am aware, of where the midwifery education program will be located.

Mr Callahan: Does your association resist, as was suggested by the nurses this morning, the additional qualification that they be either RNs or RNAs?

Ms Kilpatrick: Yes.

Mr Callahan: Not to want to advance one turf over the other, recently in British Columbia there are two midwives who are being criminally prosecuted for having practised what the crown is alleging to have been criminal, in a negligent way. I also notice that the scope of your service is "conducting of spontaneous normal vaginal deliveries."

Not that I want to give the medical profession a black eye, but I am sure we have all heard of cases where a patient has been under the care of a doctor and he happens to be occupied elsewhere, be it outside the hospital—I will not go into what activities—and the nurse in attendance very often becomes the perhaps unwilling subject of having to conduct a spontaneous normal vaginal delivery. Would you not think that in a case like that the additional qualifications of either an RN or an RNA would be of some importance, or if complications arose in, let's say, a delivery of that type and you were not in a hospital setting? I had a lot of questions there.

1540

Ms Kilpatrick: Yes. Addressing the conducting of normal spontaneous vaginal delivery, the scope of practice, the educational program will prepare midwives to conduct a normal vaginal delivery. But the bulk of the midwifery educational programs that we have investigated and that

we support the Ontario program to somehow reflect is that one of the main tools you have to be sure that you are attending a normal vaginal birth is that you assess throughout the pregnancy and you know how to detect an abnormal condition and you refer then to someone who is qualified to deal with an abnormal condition.

The Chair: Thank you very much for your presentation.

LINA DI CARLO

The Chair: We are now going to hear from Lina Di Carlo. Welcome to the social development committee. You have 10 minutes for your presentation. We would ask, if you could, that you leave a few minutes for some questions from the committee members.

Ms Di Carlo: I am not very good at this, so you will have to bear with me.

The Chair: Do not be nervous. While it is a formal committee hearing, we ask you to be quite informal and comfortable as you address the committee. We are here to listen to what you have to say.

Ms Di Carlo: In reading the answers to the House after the second reading of Bill 43, I was disturbed by two things: (1) that 22 bills were discussed at the same time; and (2) that the word "patient" kept recurring throughout the document.

In the first case, this means to me that the concerns of the disabled community are not important enough to be discussed as a bill which affects us so drastically and should have been discussed separately from the others.

Second, this bill says to me that the politicians consider individuals who use mobility aids as "patients." We are not patients. We are not sick. The health professionals rehabilitated us when we were sick so that we could live independently. So now, let us.

In this paper you speak of an exemption. This exemption regulates the care giver. It does nothing for the individual receiving the care. We do not need to be taken care of. We want the right to direct our own care and our own lives.

Also, Bill 43 is very patronizing. It says that, as we are sick, we need qualified health professionals to take care of us. Having health professionals does not equal good care.

I quote you an incident of a woman, a quadriplegic, who was a resident at an extended health care hospital, which shall remain nameless. She was given six months to live. She was in a hospital where she should have been able to receive the best care. That was not the case. In fact, it was just the opposite. Her strong desire to live gave her enough strength, with the help of some friends, to move into her own apartment with attendant care. That was over a decade ago. Now this bill would place hundreds of people's lives in jeopardy where up to now they have enjoyed an independent life.

It is ironic that the government would make \$7 million available for its disabled employees for such things as attendant care in the workplace, and also while travelling and yet it denies the very service which gets us into the labour force in the first place: attendant care at home.

Perhaps you do not understand what this bill implies to disabled individuals. This bill would make it illegal for me to clean my husband's ears with a Q-Tip or for someone to help a woman with the insertion of a tampon or help someone with toileting. Under this law, we would be criminals. Going to the bathroom is not a medical procedure and health professionals have no business in our bathrooms.

The disabled community has been fighting for attendant care for 20 years, and now in one vote you would bring them back to the Dark Ages. The government should not waste taxpayers' money in training health professionals to perform a job which is already being done. Rather, they should put more money in the attendant care services area already in existence so that the attendants are recognized for their vital contribution to our lives.

Therefore, in conclusion, I request that this bill be withdrawn or eliminate the attendant care portion from it. The fact that this bill has been around since 1982 and has never passed should tell you that it is not a good bill. Thank you.

The Chair: Thank you very much. Mr Beer has a question.

Mr Beer: You have raised a number of specific points that I am not sure are really so much dealt with by this bill, and in fairness, this bill is really quite new. People have been discussing it for 8 or 9 years, but the legislation is really within the last year or so.

But the points that you raise, I would not have thought that this bill is moving against those, but rather that both the previous government's initiative around long-term care and the present government, which is continuing that, particularly in speaking around issues of attendant care, attendant care in the workplace and a whole series of things that I think both the former government and the present government have been working on with many of the major organizations that represent the disabled—indeed there is an awful lot of activity going on and I think some quite exciting things that are going to happen.

I am struck by the comments you make, because I would not have thought that this legislation, which is directed more specifically at regulating the professions, in fact would limit you in terms of these other things that I think we all want around providing greater attendant care. I certainly want to look at this from a different perspective, but I think I would also want to say to you that I do not think, frankly, that would be the intention of any of the political parties to want to do that and that in fact there are some encouraging signs that a lot of other things are going on or are going to be taking place which will enhance independence, your independence and that of anyone else who has a particular disability.

I guess that is more by way of a comment in a sense, but certainly I think that would not be the intent of any of us with any of the bills that are before us. We would want to look at that, but I would urge you as well to look at some of the other things that are going on where I think we really are as a society trying to enhance the independence of those who are disabled.

Mr Callahan: Just to follow up on what Mr Beer said, and relying on the three instances you discussed in your presentation, section 26 says, "No person shall perform a controlled act set out in subsection (2) in the course of providing health care services." So those three examples you have given would really not be health care services; they would be assisting a person in performing functions that he or she might have performed himself had he not been disabled. If you have thoughts beyond that which would get into the definition of health care services, I think that is something we would want to look at to see if that is required, but if it is just the three things you are suggesting, then I would suggest they are not prevented by this act.

Ms Di Carlo: The bill does not address the needs of the individual. The exemption is for the care giver. It is for the professional. It is not for me to be able to direct my own care.

Mr Callahan: Yes, but the act itself is not making it illegal for you, it is making it illegal for someone who is carrying out health care services. So it does not affect you one way or the other.

Ms Di Carlo: But it does. Yes, it would affect me. If this person feels that it is illegal for him to perform a certain duty, he will not do it. Thus, my care is going to go down the drain because I will not have the care.

Mr Callahan: Well, as I say, if your examples are beyond the three you gave us, then that might be something of concern, but the three you gave us are really—

Ms Di Carlo: Which three are you referring to? I said a lot of things.

Mr Callahan: You suggested the insertion of a tampon or the—I cannot remember what the others were, but they certainly were not—

Ms Di Carlo: Well, there is a lot more that I—I do not need attendant care, but I am sure that there will be other people who will be able to be much more graphic in the details, if that is what you are looking for.

1550

Mr Johnson: I concur with Mr Beer and Mr Callahan. I think the intent of the legislation was to provide further protection for the public. Although I think there has been a misunderstanding, if I may say that, I think the intent is clear: that there is further and greater protection for the public. I get the impression you do not agree. I would like to hear you say it. Do you disagree?

Ms Di Carlo: Yes, I disagree.

The Chair: Perhaps this would be helpful. The time for this presentation is up. This is the first individual presentation we have had. We have been told there will be a parliamentary assistant. If it is the committee's wish, we could ask ministry officials to clarify for this individual at this time. Is that the will of the committee?

Mr Callahan: Good idea, yes.

The Chair: Linda, would you come to the microphone please to answer Ms Di Carlo's questions?

Ms Bohnen: The services provided by personal care attendants have several different aspects. I think this legislation would either have no effect whatsoever on some aspects, or propose exceptions to deal with some others. As several of you have pointed out, the legislation focuses on activities done in the course of providing health care services. Many routines of daily living such as tampon insertion are not health services, they are just that, routines of daily living.

Second, there is already an exception in section 27 dealing with functions performed within the household among members of the family. Many disabled people, we have been told, do receive assistance from members of their family, and that exception would cover other aspects of it.

However, both the previous Minister of Health and the current government's Health ministers have said that they do favour an exception to be created by regulation for procedures which are really on the cusp between routines of daily living and health care procedures. Those are the more invasive and hazardous things like suctioning, ventilator care, things that have a health care stamp on them, to ensure that people who are living in the community continue to do so.

All the Health ministers who have addressed it said they hoped to create this exception by regulation so that disabled consumers and interest groups would have an opportunity to participate in the crafting of the regulation so that it really does meet their needs.

Finally, for those activities which are really health care activities and do need some ongoing supervision or at least direction by health practitioners, there is still the device of delegation. Nurses can delegate controlled acts within their statutes; so can respiratory therapists and so forth. So for the most hazardous procedures, or hazardous procedures performed on the most vulnerable disabled people, those who are least capable of directing their own care, the delegation mechanism may be the best way of ensuring that the service is provided but that the quality of care is also safeguarded.

I think there has been recognition by the previous government and this government that consideration must be given to ensuring that services continue to be provided to disabled people living in the community, and there is a variety of ways in which this is going to be done.

The Chair: Thank you very much for the clarification.

EDITH GEORGE

The Chair: Next is Edith George. You have 10 minutes to make your presentation—please do not be nervous, we are very friendly—and we hope you will leave some time for questions.

Mrs George: I am a private citizen. I belong to a consumer group but I am speaking today as a private citizen.

Bill 43 as it relates to doctors is not against anybody but is for patients; I want to make that point right off the top. I have seven points here.

1. The new Bill 43 is a very much improved bill in the composition of complaints and disciplines, but I still feel an independent tribunal would be far better, or committees

with equal representation; that is to say, two doctors and two patient advocates.

Here we have an example of a lay gentleman who is one of four on the disciplines committee under the existing Health Disciplines Act, and of course he is outvoted four to one. Under the new act, it is two to one in disciplines, but whether it is four to one or two to one, the layperson must always be outvoted. I think there should be a little bit more thought given to protection of patients. It is only 15%, or perhaps a little more, of doctors who do not work error-free; nevertheless that percentage causes havoc.

2. A suggestion was made in 1990 by some members of the task force on complaints that the Ontario Medical Association should help with complaints. If that is suggested to the committee, may I respectfully suggest no.

3. It is to be hoped that the increased openness of the process means: (a) no longer must a complainant sit outside a disciplines hearing while the doctor and his lawyer sit inside; and (b) as in subsection 41(1), if the defendant is allowed 10 days to peruse the case against him, the complainant should also see the case of the defence lawyer.

4. In addition to decisions of discipline and incapacity hearings being on the register, which is of the college clause 22(1)(e), I think all admonishments should also be on the register, because these are warnings given to physicians when they are not working up to par. I think you could phone the register and they would say, "No, he has never been disciplined," but he might have had 10 admonishments. I think a little bell should start ringing in the college's head when that happens.

5. The Attorney General is proposing no limitation period for sexual abuse by doctors. I think we are starting to categorize patients here and to put them into little pigeon holes: This is sexual abuse, this is battery, this is negligence.

I do not think this is going to develop very well at all. I think all patients should be treated equally under the law no matter what has gone wrong between a doctor and a patient.

The one-year statute of limitations does not allow patients with considerable injuries to get a case together, because they are very traumatized. In addition, they do not have the money, they do not have the advantages of physicians, they do not have the insurers.

I am sure, Madam Chair, you will know all about the Advisory Committee on Liability and Compensation in Health Care, chaired by Robert Prichard, the president of the University of Toronto. He has suggested that not less than six years would be acceptable for a statute of limitations, from the time when it was known there had been negligence. But subsection 85(1) of the bill says one year.

I would please ask the committee to change that. I believe the Attorney General is trying to do something about it, but whether that is just going to be for sexual abuse or whether it is going to include all maltreated patients, I do not know.

6. Physicians should be mandated to report abuse and incompetence. Consumer groups have advocated this for years. A discussion paper of the Progressive Conservative Party, December 1986, has advocated this. In fact, they say if it is really a self-regulating profession, why do the

colleagues not bring forward complaints when they suspect one of their members may be a danger to their patients? If we are going to have self-regulation, then there really should be self-regulation from the grass roots up.

The recent task force on sexual abuse also recommends that doctors be mandated, but the OMA feels it would deny its members protection from slander and libel by other physicians wishing to hurt a colleague's reputation. Not a word that it might protect patients, just that it would possibly lead to some slander and libel. I do not believe doctors go around slandering and libelling one another. I do not know any doctor who does it. Nurses are mandated and they do not slander and libel one another, nor do lawyers.

7. The last point is, please add a clause to this bill for regular monitoring of the complaints system so that when the bill becomes law, it does not sit there for 17 years with nothing done. If you monitor it, you can see if it is working and if the college is working. If it is not, why is it not working?

Also, you can find out where most negligence occurs and why. Is it partly the fault of the facility? There are facilities—I certainly know one—where they always stress meeting the budget, but when I go to hospital, I really do not care whether they have met their budget. I want doctors and nurses and proper health care. I think the prime aim should always be quality care. Meeting the budget is good and fine, but it has got to come further down on the list of priorities.

1600

The Chair: Thank you for your presentation. Mr Callahan?

Mr Callahan: I want to address a couple of items. One, the limitation period, as you probably know, is under review—and it should well be under review—to give a commonality to limitation periods, because they are very disconcerting, particularly to lawyers who do not have a tickler system, and they cost the lawyer and the law society a lot of money. More importantly, the cause of a legitimate complainant can be lost as a result of it.

On the question about the makeup of the discipline committee, I agree with you: It says three members of the council, and it seems to be five to two, because two of those members are appointed by the cabinet, that is who the Lieutenant Governor in Council is. If you carry the process forward, if you look at the composition of council, at least seven and no more than 10 persons, of whom at least four and no more than six are appointed by the Lieutenant Governor in Council, they do not even have to be members of the particular body in question.

Mrs George: The college.

Mr Callahan: They are in fact the people who appoint, under section 15 of the act I am looking at, the Chiropractic Act—and it is probably similar in all the acts—the members of the committees mentioned in the various sections. That includes the discipline committee, so really the primary responsibility belongs to the council. It is made up of independent people, in addition to people who are members of the council. You are relying on them to

appoint appropriate people for the discipline committee, and if they are not happy with what they are doing, then they should be removing them and putting somebody else in their place.

Quite apart from that, as was witnessed in the recent case against some prominent lawyers in this city, the courts are, in fact, coming around, as is the law society, at least to the view that you have to squeal on your partners and anybody else who is involved in acts that are detrimental to the public. I for one—and I am only a substitute on this committee—think it is a matter of public policy that the government should be looking at the question of requiring this—similar to the way we require doctors to report child abuse, subject to penalties if they do not.

A similar type of reporting procedure should be required under law for all professional bodies to ensure that the public does not get—I was going to use a word that probably would not show up in Hansard—scuppered by the closing of ranks of people who belong to various professions. I happen to belong to the Law Society of Upper Canada, I would not want to see that. Nor would I think responsible doctors, dentists, or anybody in various professions would want to see that happen either.

I agree with you in that regard. I do not think it is something you will see in this act, but I would certainly urge those government members here that it is a good matter of public policy that should be brought up by your government: making it mandatory that they in fact do report their colleagues. The days of the old boys' club are gone.

Mrs George: Not quite.

Mr Callahan: The major concern should be that of the consumer and the people who pay big bucks to get those services.

Mrs George: Here we are, Mr Callahan: "Lawyer disciplined for not reporting his son." This is by the Law Society of Upper Canada. Can you imagine that ever happening at the College of Physicians and Surgeons?

Mr Callahan: That is the height of nepotism. I agree, I think that has got to change.

Mr Johnson: In number 7, your very last comment, you said: "While meeting the budget is important to health care facilities, it ought not to be the prime aim. The prime aim must always be quality care." There is a direction relationship there. Meeting the budget produces quality care. You get quality care as a result of closely scrutinizing your budget.

I am a little confused about something. Maybe I have misunderstood the point you are trying to make there. Could you elaborate on that?

Mrs George: There are facilities where they give quality care, but they do not meet the budget because they are giving quality care. To some extent, they are taking corrective work from other facilities which have not given quality care. All that corrective work is very heavy on the OHIP bill, but there is a great deal of corrective work going on when there are—shall I use the word "bungles"? I do not quite know what word to use best. Perhaps just negligence, complete, unintentional negligence.

Mr Johnson: To what particular kind of health care facilities were you referring?

Mrs George: Let me put it this way: I do not use my local hospital at all. They always meet their budget, but I will not go there. I go right downtown here to a very good hospital. I am sure they are not meeting their budget, but they really give good care. It just depends on what you want from a hospital.

I heard a nurse talking the other day about where administration in some places is top-heavy. They are cutting out nurses and they are cutting out doctors but you have got everybody at the top. As a patient, I am not terribly interested in who is sitting in an office; I want the doctor. You cannot totally blame doctors in a lot of cases. They are so stretched out, they are trying to do so many things. You go to any emergency ward and sometimes it is a wonder there are not more errors than there are. I believe it was Mr Callahan who mentioned responsibility. Everybody understands that no human institution is infallible, but surely they should be accountable when mistakes are made.

Responsibility and accountability, not perfection, because none of us is perfect, but when you have a complaint and nothing gets done and you fight for year after year—we have a woman in Toronto, 11 years. That should not have to happen. Why should I have to complain if something goes wrong? Should the doctor who sees what went wrong not complain? Should he not complain if this is self-regulation? The doctor should complain. He should go and help his peer or his colleague and say, "Look, let me show you what is going wrong here," give him a helping hand.

When I suggested this one time, I was told, "Professionals don't do that." They certainly do, because I have just shown in here what the law society does. So professionals do, and professionals should do it. Patients should be safe when they go into a facility. Otherwise put a great big notice up there letting them know.

As I say, this is just 15% probably. I say "just 15%," but 15% represents a lot of trauma, a lot of heartache and a lot of pain. I really thank you for listening to me.

The Chair: We appreciate your presentation. Thank you for addressing us.

The committee has just heard the last presentation for today. We believe there may be an opening tomorrow for a half-hour discussion with ministry staff. It looks like we may have a cancellation at that time.

Mr Beer: This is just a suggestion to the other whips. I am wondering whether we might deal with some of the points that were mentioned, that you wanted to raise anew and had not had an opportunity. I think titles was one of them.

The Chair: Is it the committee's wish to adjourn now or to adjourn at 4:30?

Mr Owens: I would not mind spending some time. Yes, 4:30.

The Chair: All right, we will ask the ministry representatives to continue the presentation now until 4:30 and then we are hopeful that there will be additional time tomorrow to continue that discussion. The committee is in

session. We will continue discussion with the representatives from the ministry. I believe that everyone has the documents before them. We were at tab Mc.

1610

MINISTRY OF HEALTH

Ms Bohnen: Just before you turn to tab Mc, I would like to remind you that under tab I there is a little document that shows how the review summarizes some of the concerns that were expressed by interest groups about title provisions. Those are the review proposals that have been contested by professions which are motivated in part by status concerns and attempt to create or maintain an economic monopoly and the desire to do indirectly what has been directly prohibited. Status concerns are that some titles connote more status than other titles. It is as simple as that. It is not necessarily a bad thing, but it is a fact of life. For example, "technologist" is a higher-status title than "technician."

With regard to the other two points, monopoly and doing things indirectly that you cannot do directly, you may observe the fact that the professions which are most concerned about the title protection and how it is expressed in the bills are those which have no or few controlled acts. One could analyse their situation as the profession in competition with unregulated groups because there are not controlled acts restricting the service to the regulated group. If you cannot control your competition by a law that says the other group cannot do it, another way of trying to secure an advantage is by restricting a title and trying to steer the public, by use of that title, to your group or yourself instead of to your competition. That is not to say there are not public interest aspects to the debate, but titles are also another way of achieving economic advantage.

Mr Burrows: Just to add, there is a large body of academic literature widely available to support what Linda has said.

Mr Johnson: From a public perspective, it would appear to me that this might be just semantics in title. The family practitioner is a doctor. If somebody said, "I am going to see my family practitioner," I would make the assumption that he is going to see the doctor and I do not think any less of him because a layperson has called him a family practitioner. I guess it is the organizations themselves that have the greater interest in what their title ultimately is because, as you have already indicated, it may mean more money, it may mean more work is directed their way.

I do not see it as being as controversial, or maybe I do not see it as being the sort of thing we would want to interfere with. If a particular organization did not conflict with another organization with regard to title, then would not the title that it wanted be the best title for it? We would not get into any adversarial situations then.

Ms Bohnen: There are adversarial situations, though, because some titles are claimed by more than one group or words derived from the title are claimed by more than one group. You heard from physiotherapists today that they would like protection of the title "physical therapist." It is the case that some other professions, such as chiropractors,

believe they also provide physical therapy. I think you may fear from them that they would be concerned if restricting the title "physical therapist" to physiotherapist meant that they, as chiropractors, could not describe some of what they do as physical therapy.

There are several different kinds of title issues. You have already heard the "doctor" title issue. It might be helpful to clarify that a little bit.

The Chair: I have Mr Cordiano and Mr Beer and both have questions relating to the doctor issue. Is that correct?

Mr Cordiano: Can I just say something at this point before we get into that? I think the way I would try to configure this so that I could understand it would be to attach some sort of value to a title on the basis by which that profession claims to have that title. So if that profession wants to be called doctors, is it in relation to the kind of training, the kind of value added to the profession that we would then, as a group, as a committee, say, "Yes, this is justifiable?"

Ms Bohnen: Why do we not start by seeing what the bill actually says in terms of the restriction on the use of the title "doctor," because doctor is an issue. Section 30 of the RHPA says (1) "Except as allowed in the regulations under this act, no person shall use the title 'doctor,' a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals."

The only restriction on doctor applies to providing or offering to provide health care to individuals. Some academics, some people with PhDs in unrelated fields initially thought that meant they could not use the title "doctor" in a classroom, in administration, at a cocktail party. That is clearly not the case. We are only focusing on the use in health care settings and providing health care to individuals.

Mr Owens: Just in line with the speech pathologist who was here, who would be involved in the provision of health care as we understand it, and the physiotherapist providing health care as we understand it, would they not then be restricted?

Ms Bohnen: I am trying to work through this systematically. First of all, we do not have a problem with our non-health-care academics. They can call themselves doctor. Then we have our people who are health professionals providing patient care who do not belong to one of the five professions authorized to use the title "doctor." You are quite right. You heard from a speech-language pathologist and a physiotherapist in that situation. This is when you come down to government's decision-making.

Mr Owens: Politics.

Mr Cordiano: You asked the question.

Ms Bohnen: I would not say it is politics. I think governments have viewed this as a difficult social question.

Mr Owens: Scary, is it not?

Ms Bohnen: Governments have decided, so far, that most Ontarians think that when they hear the word "doctor," they are dealing with a medical doctor or a dentist or a chiropractor or a psychologist. Remember, those profes-

sions all have something in common. The basic educational qualification for entry to the profession is a degree or a diploma that says "doctor" on it. You cannot practise medicine, psychology, dentistry or chiropractic without a doctor's degree. But you can practise speech-language pathology, etc, without that degree. Some of their members have those degrees. In fact, a minority have doctorates; most of them do not. Most of them are prepared at the bachelor's or master's level.

Mr Owens: My understanding, if one wants to get really technical about this, is that a person who graduates from medical school simply has an undergraduate degree and that it is only when one enters a specialty through the Royal College of Physicians and Surgeons of Canada that one is actually entitled to use that post-graduate—

Ms Bohnen: No, that is not correct. The degree granted in Canadian and American medical schools is doctor of medicine. That is their entry-level academic qualification. It is the same thing for dentists and the other professions I mentioned.

You have heard and you will hear from groups which say: "No, Ontarians don't think that way any more. They are able to discriminate among every health care provider and they are not misled by the use of the title 'doctor.'" All I can say to you is that the government, in these bills, decided that doctor should be restricted to the professions authorized to use the title "doctor," the interest being in not confusing people about the qualifications of the person they are obtaining care from.

I guess there are two levels to the issue. One is before you. Should use of the title "doctor" be extended to other regulated professions? Beyond that, you may hear from some groups which also have PhDs but are not regulated as to whether they should be able to use the title "doctor." It is not a complicated issue; it is just an important social issue that you are going to deliberate on.

Mr J. Wilson: Essentially you are telling us that this continues the current practice.

Ms Bohnen: It modifies the current practice in so far as it legalizes the use of doctor by chiropractors and clarifies that psychologists who customarily use it are entitled to do so, say, PhDs. For the other professions, medicine, dentistry, optometry, it is current practice.

Mr J. Wilson: Okay. It was also suggested yesterday that perhaps you may not have any real grounds to prosecute someone who decided he would continue, because he had a PhD like our speech pathologist, using the term "doctor" in front of his name in a hospital.

Ms Bohnen: Arguably, today they are violating a section of the Health Disciplines Act. The Health Disciplines Act restricts these titles.

1620

Mr J. Wilson: That is what I was wondering: Has anybody bothered to prosecute anybody for this?

Ms Bohnen: Time was when the College of Physicians and Surgeons warned chiropractors most particularly and complained to their governing body. But I am not aware that they have gone after a speech-language pathologist or

groups like that. I cannot conceive that they would now consider that necessary, remembering that many speech-language pathologists practise in institutional settings where there are safeguards against confusing patients. It may be that this is the sphere across which the regulation, making an exception to this prohibition, would apply.

Mr Beer: I appreciate the points you have made about this and I think you are quite right to underline that it is not in a real sense a technical problem. It is a governmental or political decision in the best sense of that terminology regardless of who the government is, because we are reflecting or trying to reflect what we think the norms are. I guess what strikes me is that as we look at it, can we find some principles here that can guide us? One of the questions, and you may have the answer to this, was that in Europe and in the United States if somebody has a doctorate he may use the term "doctor." In point of fact some do and some do not, but there is not a prohibition.

It is as if we are using a sledgehammer on the proverbial fly instead of a fly-swatter. I think that is something as a committee we are going to have to wrestle with. I know there are going to be other presenters but I think it is a valid issue, in that on the one hand you are saying to somebody, "You went through a course of study, you received a doctorate as did somebody in history or somebody in philosophy, but we are saying that you can use that title in certain places but not in others and there is a rationale for that."

The issue for us is, is that any longer an acceptable rationale? Does that affect the public interest or does that affect in some way potential harm that might befall someone? Those are all very legitimate questions which we have to answer. My sense, though, is that the overall thrust of this legislation has been to open. This, while it clarifies it, also closes and I do not know if that is the direction we want to go in. I am not sure what my own answer is yet and I want to hear more on it. This is helpful but I just sense that we are legislating in some areas that perhaps do not need legislation.

Mr Cordiano: I would just reiterate what has been said already. My concern is that if someone has a doctorate, if he is not in one of these groups that have been exempted, he may be like our speech pathologist who has a doctorate and not everyone is required to have a doctorate in speech pathology to practise—correct? That is where our difficulty lies: trying to draw the line here. We on the one hand will sacrifice those who have a doctorate who somehow deserve, in my opinion, to be called doctors, whether it is in health or in some other field of practice.

It happens to be that they chose health for their field of practice and their profession. I think it is a tough decision to make to call and draw the line at that point and say that they are not going to be allowed to use that title when I think it is rather important for them to be able to use that title. If you create that kind of distinction, as you tried to point out earlier, it creates a monopoly—it certainly does for the groups that have been included here—and I think the same kind of logic could be extended to those who have a doctorate and who are not included here and have

fallen in the cracks, if you will. I would like to see that addressed and I think we should pursue this.

Ms Haeck: I do have a question for the ministry staff. In discussing this issue various people have remarked on the fact that in dealing with medical practitioners in a hospital setting frequently the badges identify the specialty of the attending specialist. So seeing a person in a white coat who happens to be called "doctor" does not necessarily mean that he is a physician. You could read that as part of the identifying name tag the person is wearing.

Is this consistent practice or is this something that one institution or two institutions across the province happened to initiate? Thereby we are faced, as you so rightly pointed out, with people being faced with this array of people standing before them in white lab coats and trying to figure out who really is the physician and who is the speech pathologist, but they are all called "doctor." I am just wondering if there is some way of making sure that there is clarity in a simple identifier.

Ms Bohnen: The health professions review suggested that there be a statutory exception for individuals practising in hospitals, nursing homes and other regulated settings where, as you suggested, the administration can be expected to have some rules about what the name tags say. It was legislative counsel's view and I think the ministry's view that this kind of exception may well be very appropriate, but it is better done by regulation and there is regulation-making authority in the act to do that by regulation. It may address part of the problem sectors in which there is less likelihood of individuals being misled. Again, as I suggested, there is probably less likelihood of people being misled by regulated practitioners whose colleges will discipline them presumably if they mislead their patients. It is harder to get a handle on it for unregulated people.

I would just like to remind you, though, that this is not a new prohibition. The Health Disciplines Act prohibits anybody other than a dentist, physician or optometrist from using the title "doctor" as an occupational designation relating to the treatment of human ailments or physical defects. These bills have updated that rather outdated language but it is not a new prohibition. It has been expanded to cover chiropractors and psychologists because of common usage and the nature of their educational qualifications.

Mr J. Wilson: It seems to me that society does place a fairly large emphasis on status. We saw from our speech pathologist, for instance, that if he were allowed to call himself "doctor," he felt that he was of the same status as the medical doctor who is on the same page, same itinerary. It seems to me what society forgot, and one of the reasons that Canada has this problem with the titles, is if you go to a graduation ceremony at any university the PhDs in philosophy are given out first. They are the highest degrees attainable in academia, and actually a medical doctor's degree or a chiropractic degree is an undergraduate degree and of little significance compared to a PhD.

I have always felt sorry for the PhDs and their inability to use it in everyday usage because actually in academic circles and in the hierarchy of things they have higher degrees and yet they are not able to get the recognition I

feel they deserve. They spend many more years in school, for instance. I have a brother who spent 15 years getting his PhD in zoology and he teaches medical students but cannot use the term "doctor" because he is confused with a medical doctor.

We cannot change society and I have really no intention of changing the act the way it is proposed but I did want to put that on the record because I am going to mail it to my brother.

The Chair: Mr Hope, the committee has agreed to adjourn at 4:30. You have one minute.

Mr Hope: There is just one comment I would like to make. You mentioned that they were not supposed to use the title "doctor" but they did, and I notice you moved your little red book there—

Ms Bohnen: Sorry, I wanted to read from the existing section.

Mr Hope: Oh, okay. But we have people using the title "doctor" in the medical fields, health providers. They were not supposed to but they did. Why did somebody not do something to make sure that we were not into the problem we are in today?

Ms Bohnen: There was a time when the College of Physicians and Surgeons of Ontario, which polices the title

"doctor," did try to warn off some other practitioners from using the title, but faced with, I guess, hundreds of other practitioners and increasing public acceptance that they could use the title "doctor"—you would have to ask the college. It may be they decided that this kind of enforcement activity was not worth the expense and the poor public relations involved in doing it. They also probably felt that these bills would sort out the situation.

Some groups, because they have had their diplomas or degrees that say "doctor," have felt that they had a colour of right to use the title. Other groups have not. Remember, we heard from speech language pathologists, nurses. We are talking about very small numbers of practitioners in those fields with doctorates, unlike every chiropractor, who has a "doctor" diploma. So the numbers are quite different.

Mr Hope: So that would move pretty well into the comments of the lady who just did a presentation to us about some of the accountability issues.

The Chair: The meeting is formally adjourned. We will reconvene tomorrow morning at 10 o'clock. It has been an interesting day.

The committee adjourned at 1633.

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Regulated Health
Professions Act, 1991
and companion legislation



Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le jeudi 8 août 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent

Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 8 August 1991

The committee met at 1003 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi de 1991 sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ONTARIO CHIEF PSYCHOLOGISTS ASSOCIATION

The Chair: Good morning. Welcome to the standing committee on social development.

We are going to begin this morning with a presentation from the Ontario Chief Psychologists Association, Patricia DeFeudis. The procedures for the committee are that you have 20 minutes for your presentation, and we ask that you save some time so that we can ask some questions, if there are any questions from members of the committee. While this is a formal meeting, please relax, do not be nervous, and welcome. If you will sit down and speak into the microphone so Hansard can pick up the names, that would be helpful.

Dr DeFeudis: Fine. My colleague Dr Ferguson will make the presentation, and we will be glad to answer and discuss with you the issues. Thank you.

Dr Ferguson: The whole process of being involved in legislation is not our business and it is brand-new to us. It has certainly given us an appreciation of the difficulty in drafting good legislation, perhaps particularly when that legislation has goals both of broadening and restraining or controlling things people do.

In general we applaud the legislation, its goals and its nature. The Ontario Chief Psychologists Association, as you might imagine, is dedicated to improving health care and access to health care. We are particularly interested in those aspects of the legislation aimed at facilitating greater flexibility of roles for health care providers, as we believe that psychology and psychologists, as well as other professions, are capable and deserving of greater scope than sometimes may have been awarded in the past in our health care system. Because of that we look forward to the passage of this legislation into law and moving on to the review of the Public Hospitals Act.

I am going to be brief and bring to you the concerns we have; not the broader concerns of the profession of psychology, but the concerns the legislation brings to us as we

practise within the hospital system in Ontario. There are mainly two.

The first one I want to touch on relates to the issue of diagnosis as a controlled act. It is our understanding that some professions have raised questions about the need for retaining diagnosis as a controlled act. Diagnosis is one of the core functions psychologists carry out in hospitals. We are very frequently called upon by our colleagues to make diagnoses. We realize diagnosis is a very important function, and it is also one which is, to perhaps use a word that is risky, a dangerous one. In psychology over the last 20 or 30 years we have learned painfully the difficulties labelling can cause the people we work for. None the less, it is simply because the dangers of labelling are so pronounced that it is clear to us that diagnosis needs to be a controlled act.

It is our view that psychologists are well prepared, both through their education and their inside training, to carry out the process of diagnosis as it has been defined in the scope of practice in the proposed legislation. Not only that, but there are some areas where in fact psychology is clearly the very best profession to make diagnoses, and examples of those areas would be in diagnosing personality disorders and mental disorders and in diagnosing learning disorders with children.

While we feel diagnosis should be retained as a controlled act, and that it should be retained as a controlled act for psychology as it is described in the legislation, we are also mindful of the needs of others of our colleagues to assess and communicate their findings with regard to treatment within their scopes of practice. We urge you in this committee to give some thought to making the distinction between assessment and diagnosis and allowing many of our colleagues clearly the right to communicate the results of their assessments.

The second area where we have concerns relates to title protection. As you have undoubtedly already heard, the new Psychology Act would change title protection for psychologists. The broader issues for professional psychology will be addressed enthusiastically and in detail by our regulatory body, the Ontario Board of Examiners in Psychology, and our professional association, the Ontario Psychological Association, so I want only to look at one area that relates to us in hospitals.

In our hospital practices, many of our staff members are frequently involved in assessment and feedback and treatment and planning in areas relating to education; psycho-educational assessments of children and the follow-up of those assessments, and forensic assessments for the court.

As we understand the current legislation and the definition of health care that might ensue from that legislation—and we have not obtained an independent legal opinion on this; we are relying on the legal opinions obtained by our regulatory body and by our professional association—we

are concerned that we would have staff members who would be practising in the educational and forensic areas within the hospital who would not be regulated while they carry out those particular jobs. We are concerned because for us in the past all the things our staff have done have been clearly regulated.

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We are also concerned because these two particular areas are often contentious and sometimes involve litigation. Since what psychologists do in those areas are not controlled acts, we feel that quality assurance in those areas then rests on having the services provided by regulated practitioners. We do not have a clear proposal for how to iron out that difficulty. One possibility would be to move to a definition of health care which would clearly include those areas of psycho-educational practice and forensic practice that our hospital staff members had been involved in for many years. I think that is the core of what I want to say. If you have questions, Dr DeFeudis and I would be glad to try and answer them.

Mr White: As chief psychologists, you would be chief psychologists in hospitals?

Dr Ferguson: That is correct.

Mr White: So you are not referring to what would be, say, a chief psychologist of a board of education or whatever, but entirely within the medical field.

Dr Ferguson: Entirely within the public hospitals of Ontario.

Mr White: I think you were absolutely accurate with regard to learning disabilities, etc. I recall in the past a colleague, a psychologist, just doing an incredible job in assessing learning disabilities. I was just amazed at the accuracy of the assessment or the diagnosis, depending on your phraseology, and the treatment and recommendations, which were extremely specific and helpful for the treatment staff. In the hospital setting you would usually have a multi-team comprising social workers, psychologists, psychiatrists, etc.

Dr Ferguson: Most often, not always.

Mr White: And I am sure as well that the psychology department in some areas is staffed alone with psychologists and perhaps some psychometrists underneath them. Within the mental health clinic, the multidisciplinary clinic, what would be the approximate proportion of those staff?

Dr Ferguson: What proportion are psychologists?

Mr White: Yes, or psychology staff. I guess that is a very accurate phrase. First off, what proportion would be psychologists? What proportion would be psychological in the mental health clinic? Do you have any idea?

Dr Ferguson: As an association, every two or three years we do a survey of our member hospitals in Ontario. In our hospitals the majority of psychology department staff are psychologists. We have only one hospital where it is not the majority and I believe that is my own, and we only have one other hospital where the ratio approaches 50-50. So in the majority of hospitals, most of the psychology department staff members are psychologists, not psychometrists.

Mr White: And the psychometrists would be people with their MAs in psychology.

Dr Ferguson: Yes.

Mr White: And upon the multidisciplinary teams, the mental health clinics, etc, do you have any idea what the breakdown would be by profession?

Dr Ferguson: If they were mental health clinics designed as such, I believe psychologists likely would make up between 25% and half of the staff. That probably varies from clinic to clinic. Within my own hospital all of the services are multidisciplinary. The proportion of the service that is psychology staff depends on the nature of the service. For instance, in the forensic service there is proportionately more psychology staff and neurologically oriented service.

Mr White: You mention here the distinction between assessment and diagnosis. We had a lengthy discussion of that issue yesterday and I am sure it is not as yet resolved to everyone's satisfaction. How do you think that distinction could be made to meet the needs and practices of your colleagues in the mental health or other health professions? I am speaking here, of course, of mental health.

Dr DeFeudis: We made a suggestion in our brief that we presented today for a generic "notwithstanding" clause which would read something like the controlled acts regarding communicating the results of an assessment. Professionals registered by their respective colleges are exempted from this restriction in so far as the communication relates to the results of assessments performed within their scope of practice. In other words, one can communicate what one has accomplished through an assessment, and that is not the diagnosis. But one should not be restricted in doing that and we certainly feel very strongly that all professions should be allowed to do that.

Mr Beer: Thank you for your submission and also for your suggestion about what an exemption might look like. I think, and you have noted it, that one of the issues we have to wrestle with is not only how we read this definition of diagnosis and assessment, but recognize that if there is to be a change that seems to fit one group, what are the implications of that for another. This whole thing is such a balancing act that one is concerned about how those all fit together.

I just wanted to go back, because one of the things for us as laypeople is in understanding what it is you do today and what this act, were it to pass unamended, would mean so we have a clearer sense of what might limit you today in your practice within the hospital. Is there an example you could give us of a kind of activity or case you would deal with today in a hospital setting where, if this were to go through, you would feel you could not do it, or there would be some limitations, just to give us a more practical sense from the day-to-day experience.

Dr Ferguson: I would like to try that. As directors of psychology working in Ontario public hospitals, we fall not only under Ontario law, but our hospitals are accredited nationally, so there is a Canadian Council on Health Facilities Accreditation. For our institutions to be accredited, one of the things we are charged with is the assurance of good quality psychological services within the hospital.

One could argue that we are stretching a point, but the way the new legislation is set up, as we understand it, a hospital—not all hospitals have psychology departments—or a health facility could set up psychological services. Because the words “psychological” and “psychology” would no longer be protected they could set up a psychological services division which would not of necessity have to be supervised by a registered psychologist. That cannot happen now.

On the other hand, I cannot look at you in good faith and say the way the legislation is set up will prevent me or Pat or any of our staff from delivering service to people. However, the business of controlling the quality of the service is the thing she, I and our colleagues are more concerned about. That is the aspect of the title protection that we are concerned about.

Mr Beer: That is very helpful for us in trying to understand what is the essence of the problem and how the present legislation regulation compares with what would be coming, because we are going to be continuing to talk to people in the ministry and also to Alan Schwartz around some of these issues.

Dr DeFeudis: Another concern would be the definition of health care. Again, it depends on how wide the net is cast. Psychologists tend to go in and out of—if the definition is very narrow, our functioning may go beyond the definition. However, if it is a fairly broad definition, for example, consulting in a child and family service, one is frequently also making contact with the school. If that contact with the school around treatment for a child is considered health care, what is done would be controlled. If it is not considered health care, then what is done would not be controlled. It would be that kind of a very grey—we understand—situation. It may be that a definition of health care can fit this—for example, a definition of health care that encompasses all the controlled acts, an operational definition that brings in the concept of all the controlled acts, so therefore health care may be adequate.

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Mr J. Wilson: You have heard my questions before. Thanks for the presentation.

I am still grappling with the terms “assessment” versus “diagnosis.” The way I read this—a cursory reading anyway—is, at the PhD level, those psychologists are able to offer diagnosis within the hospital setting and the “notwithstanding” clause you would like to put in is to cover the masters.

Dr Ferguson: It also would cover other professions who have not been offered diagnosis as a controlled act. Academics have had discussions for years about the difference between diagnosis and assessment and the way the legislation approaches it now has to do with attribution of causality. While we do not think that is perfect, that is something we feel we can live with within our institutions, and it does encompass at least a good part of what we feel is important about diagnosis and what separates it from assessment.

For instance, an occupational therapy colleague of mine will assess a child's functioning in the motor sphere and maybe a little bit even in the visual sphere. If they are

going to develop a program to improve a child's fine motor co-ordination, then I think it is fair that they be able to sit down and communicate the results of their assessments so they can explain why they are going to do what they are going to do, and how in fact they are going to judge whether it is working, so the parent and the child can understand the whole reason for doing something. They ought to feel that is comfortably within what they are allowed to do.

The Chair: Thank you very much for your presentation. The committee has decided to allot 20 minutes, and if we take more time for one, it means less for someone else. We appreciate very much your coming before the committee this morning.

Dr Ferguson: Thank you very much for the opportunity and good luck.

ONTARIO COLLEGE OF PHARMACISTS

The Chair: The next presentation is from the Ontario College of Pharmacists. I would remind all members when questioning that we are trying to ensure that all of those who want to ask questions have time, so if you could just be aware of that, it would be helpful.

Welcome to the standing committee on social development. As you know, we are hearing representations on the Regulated Health Professions Act. You are from the Ontario College of Pharmacists and you have 20 minutes for your presentation. We would ask that you leave some time for questions at the end if that is possible.

Mr Truong: My name is Nghia Truong. I am a practising pharmacist from the Ottawa area. I am presently the president of the college. I have here with me the registrar of the college, Mr Jim Dunsdon, and in the gallery we have our solicitors, Mr Phil Isbister and Mr Gordon Meiklejohn.

The Chair: They are welcome to join you at the table, if you would like. We can get additional chairs.

Mr Truong: The Ontario College of Pharmacists is pleased to have this opportunity to make this presentation respecting bills pertaining to certain health professions. Our comments are confined to two bills: the Regulated Health Professions Act, 1991, and the Pharmacy Act, 1991.

Let me give you a brief history of the college. The Ontario College of Pharmacists has been the licensing and regulatory body for pharmacists in Ontario since 1871. Its responsibilities also include the accreditation of pharmacy premises and the regulation of the sale of drugs to the public of Ontario. There are currently some 7,700 licensed pharmacists on the college register and 2,000 accredited pharmacies. This college is governed by an elected council of 16 pharmacists, the dean of the faculty of pharmacy and six public members appointed by the Lieutenant Governor in Council.

The council is the overall policy and planning body, under the chairmanship of the president. An administrative staff of 32 persons, including 17 pharmacists, works under the direction of the registrar and the deputy registrar, and the college departments include drug information, education, field services, investigation, licensing and registration.

The college has worked closely with the Ministry of Health with respect to the discharge of its statutory responsibilities as well as proposing statutory changes and the making of regulations, subject to approval by the Lieutenant Governor in Council and with prior review by the minister.

The college supports the proposed legislation which has taken many years of consultation to develop. We have been actively involved both with the Health Professions Legislation Review and the Ministry of Health in its development over many years and are pleased that this important legislation is now being brought forward. We do, however, have a few concerns which we wish to identify with you today.

1. Membership of governing council: The Ontario College of Pharmacists strongly supports the recommendation of the Health Professions Legislation Review concerning lay representation on councils.

The requirement for one third of the membership to be composed of lay people ensures an effective public presence, while preserving the principle of self-governance. It will preserve the climate of meaningful and effective dialogue at the council table as well as keeping the size of council at a workable level. The inclusion of lay members on the council, established under the Health Disciplines Act, has worked well in our experience and is endorsed.

We are, however, concerned that the proposal to increase this membership to just under half will impair the effectiveness of policy deliberations and seriously erode the principle of self-regulation. The HPLR came to its conclusion on this matter after years of study and its recommendations concerning council and committee composition should be accepted.

2. Use of title "doctor": The proposed legislation would prevent pharmacists who have earned the academic degree of doctor, either by obtaining a doctor of philosophy or a doctor of pharmacy degree, from using this title as a vocational designation. It is our submission that provision should be made to permit such pharmacists to use this title in the same fashion as certain other health professionals.

I would ask now the registrar to continue.

Mr Dunsdon: We have five other items we would like to very briefly highlight and then we would be very happy to entertain any questions you might have.

3. Discretion of the discipline committee: The proposed legislation compels a discipline committee to make a finding of professional misconduct even for a technical breach of the statute. The present Health Disciplines Act, under which we operate, provides for discretion in making such a finding, and we believe that this discretion should be retained. Resorting to a lesser penalty to exercise compassionate discretion is not, in our opinion, a satisfactory approach and removes an element of discretion currently available in the courts, where partial or complete discharges are ordered in appropriate cases.

4. Pharmaceutical services in hospitals: The provision of drugs to patients in hospitals, that is, the distribution of drugs to those patients and other health or custodial institutions, is exempted by these proposals, as it is under the current Health Disciplines Act. We agree with this exemption; however, it is our position that the pharmacy service

itself be directed by a pharmacist who is registered and accountable to the college for his or her professional activities. Cases such as hospitals in remote areas, which are unable to secure such services, would be exempted by regulation.

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5. Communicating information on investigations: We think it is important that the legislation enable persons making investigations under the act to share appropriate information with such agencies as the police, with inspectors appointed by the bureau of dangerous drugs and with investigators of other colleges.

6. Deputy registrar: We feel it is essential that the legislation should recognize the appointment of a deputy registrar as is the case in the present Health Disciplines Act, so that such a person, if he or she is appointed, has the powers of the registrar in the absence of the registrar.

Finally, a matter we have just added to our submission term limitation for elected members: Last week draft government motions to amend the Regulated Health Professions Act, 1991, and certain other companion bills were released.

These motions were described as technical and in the main they were, but there were a number of matters involving policy-making by our council, including most significantly a legislative amendment to limit elected members of the council to serve for not more than six consecutive years. Ontario pharmacists have had the democratic right to stand for election to council and to elect candidates of their choice to council since the establishment of the college about 120 years ago, and these rights are fundamental.

There has really been insufficient time for us to give proper consideration to this important issue and we would like to reserve further comment at this time. We will, however, put forward our position to the committee on this matter as soon as we have had an opportunity to discuss it and I expect that opportunity will arise within the next two or three weeks.

We thank you very much and appreciate the opportunity to come.

The Chair: Thank you very much, and of course your organization as well as individuals can continue through the course of these hearings to communicate in writing at any time with the committee. We will be pleased to have written presentations from anyone interested in this legislation.

Mr Owens: I would like to ask a question around your comments in point 1 regarding the increase of laypersons on the committee. Could you explain a little more fully how you feel that will dilute the principle of self-regulation and hinder your effectiveness in policy discussions?

Mr Truong: Right now on our college council we have six public people and 16 pharmacists elected, and the dean. With that quota of public people versus elected people we have a good rapport. We can work closely because we consider the public people as part of the council membership. If we start thinking having half, the membership would be so great, the council will be so big that we would have very difficulty in having any significant debate or deliberation.

Mr Dunsdon: We feel the 23-member council is an appropriate number to properly discuss matters and deliberate

on policy. Under this particular proposal, and assuming that our electoral districts did not change—indeed we would like actually to increase them by one because of the population increase of pharmacists over the years—we would be faced with well over 30 people on our council. I think that is the essential problem we have in terms of effectiveness, that we would have 34 people on the council. We have a concern that that would create problems of effective deliberation because of the large numbers.

The principle of self-regulation, we feel, was appropriately dealt with and addressed by the HPLR. At present we are at about a quarter. A third would have appropriately addressed the public concerns in that regard and at the same time preserved the principle of self-regulation.

Mr Beer: With respect to investigations, you mention here that you would like the legislation to enable persons to share appropriate information. What is the status right now? How is that done?

Mr Isbister: As matters now stand, you cannot share information from college to college, for instance. This means that when there is an investigation by our inspectors and they see something not right on the part of the doctors—which can happen, because they are the ones who issue the prescriptions and give the orders—under the present confidentiality section we cannot tell the College of Physicians and Surgeons, and we think this is wrong.

Mr Beer: When you say “the present” do you mean the existing legislation or this new legislation?

Mr Isbister: My understanding is that that position is being maintained.

With respect to the police and the bureau of dangerous drugs, we are in the same position technically. If we find somebody pushing narcotics out the back door, we cannot tell them. They can tell us if they find something, but we cannot tell them. We think it is appropriate and very much in the public interest that this information be shared.

Mr J. Wilson: In the use of the title “doctor,” the language of the act is to restrict it to “in the course of providing and offering to provide health care to individuals.” Do pharmacists come under that definition of providing health care to individuals, as far as you understand?

Mr Dunsdon: Yes.

Mr Truong: Pharmacists working in a community pharmacy or in hospital, like myself, cannot use the title “doctor” although we provide a service to the public.

Mr J. Wilson: This might be a dumb question but is dispensing drugs considered in this act, as far as you are concerned, an actual health care hands-on service?

Mr Dunsdon: Yes. We consider that a service. The practice of pharmacy involves both the dispensing, the nuts and bolts aspect, as well as what we like to call clinical pharmacy or patient-oriented practice. This legislation would prevent people who have an earned degree from saying they have an earned degree as a vocational designation. The numbers of doctor of pharmacy people is not huge in comparison with the 7,700 members, but it is an increasing phenomenon. It is not uncommon in teaching positions in hospitals, and it is becoming not that uncommon in

community practice as well, Dr Truong being an example. There presently is no discretion in the legislation for someone like Dr Truong to call himself Dr Truong when he is practising in community pharmacy as a pharmacist.

Mr Callahan: What is your doctorate in?

Mr Truong: Doctor in pharmacy.

Mr Callahan: I thought you had suggested that a person who has a PhD should also be able to use the term “doctor.” Surely this legislation is for consumer protection and information, and to have somebody dispensing drugs or, for that matter, conducting any type of health service with a doctorate in something other than that particular field is not helping the consumer understand what is going on.

Mr Truong: I could elaborate on that. There is a PhD in pharmacy and there is a pharmacy doctorate, which are two different degrees. The PhD in pharmacy is more involved in pharmacology, specializing in pharmacology, but a pharmacy doctorate is just specializing in pharmacy and is a short diversion.

Mr Callahan: I thought I heard you suggest that a person who has a doctorate in philosophy—

Mr Dunsdon: They both have earned academic degrees; a PhD or a PharmD are both earned academic degrees.

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Ms Haec: I would like to refer to your last item, term limitation for elected members. I realize you really have not had a chance to examine all of this, but what is the longest elected membership within your college that you are aware of?

Mr Dunsdon: At the present time?

Ms Haec: Yes.

Mr Dunsdon: I believe one member has been on council for 10 years at present.

Ms Haec: As far as a concept of having a sunset provision for members goes, bringing in new blood but then possibly allowing people to stand again, I think there is no limitation here as far as somebody being able to stand again after being off of the board for a while. Do you see that as being problematic?

Mr Dunsdon: I am not sure, because we have not had a chance to talk about it. I think that is one aspect we want to look at. The six consecutive, as you say—it could be a George Wallace of Alabama type of approach. We would want to look at all aspects of this before we comment further.

The Chair: Thank you very much for your presentation. We appreciate hearing from you today and look forward to your written submission when it is ready.

MINISTRY OF HEALTH

The Chair: The Society of Independent Community Pharmacists is not here now, so we will ask the ministry to continue its presentation at this time. We have until 11:10 available. Mr Cordiano said he had a question to lead off. I will make a list.

Mr Cordiano: I want to zero in on the title question again, the use of the term “doctor” that you just heard pharmacists talk about. I think we need to establish some

consistency, and until I am convinced that we are being consistent—wherever you choose to draw the line is fine with me as long as we are perceived to be in continuity with everything else and there are logical reasons for having done what we did.

Let us use the pharmacists and compare them to, say, a medical doctor. The pharmacists have a four-year program, I believe.

Ms Bohnen: I believe so.

Mr Cordiano: After which they are granted a degree.

Ms Bohnen: Yes.

Mr Cordiano: Which is what? What is their degree?

Mr Burrows: Bachelor of science in pharmacy in Ontario, but there are also many pharmacists who have the degree of PharmD, doctor of pharmacy, which is a five-year degree. In addition to the academic requirement, there is a practice requirement of one year in Ontario. So it is five years, a combination of education and practical experience.

Mr Cordiano: How does that compare to a medical doctor?

Ms Bohnen: To try to answer that and to address your concern about consistency, the answer would be that in Ontario the basic degree which entitles a pharmacist to registration with the college is not a doctor degree.

Mr Cordiano: It is not a doctorate.

Ms Bohnen: The degree does not say "doctor," whereas for the physicians, the psychologists, the dentists, the optometrists, the chiropractors, their basic, entry-level academic qualification for registration with their college is a degree or, in the case of chiropractors, a diploma earned in Ontario that says "doctor."

Mr Cordiano: That is a technicality, though, in my opinion. It is the college's or the institution's or the government's decision to grant that degree with the title "doctor" included in it. For example, a chiropractor would be granted a degree or a diploma which says "doctor of chiropractic." Correct?

Ms Bohnen: The charter that established the Canadian Memorial Chiropractic College entitles them to issue credentials that are diplomas but use the title "doctor."

Mr Cordiano: Really it is a technicality stemming from what the charter provisions were at the time they were granted.

Ms Bohnen: I do not know whether I would call it a technicality or not. That is just the factual information I can provide you with.

Mr Cordiano: But what I am trying to say is it is the use of terminology and more a semantic question. I am Mr Consumer out there thinking, "What kind of qualification"—I think you have to equate the two—"or what assurance of qualification is there when someone calls himself or herself 'doctor'?" I think it is all a question of arbitrary determination in that case, stemming from a granting of a charter which in the beginning says, "This degree shall have the use of the term 'doctor' in it."

Ms Bohnen: I guess the other aspect of it is that I do not think most Ontarians associate the title "doctor" with pharmacists. As we have heard, there is a small number, a growing number of pharmacists who have a doctorate. Presumably most of them are in pharmacology or pharmacy—some may not be; I would not know—whereas people associate all physicians as Dr Whoever.

Mr Cordiano: I am having difficulty because in my mind a pharmacist is part and parcel of the health care system. Shall we say he works almost exclusively within the health field.

Ms Bohnen: Yes.

Mr Cordiano: I do not think you can find an example where a pharmacist is working outside the health care field. My concern is to be consistent and have a sense of continuity where we draw that arbitrary line. I am having difficulty with this example. I am still not convinced at this point that we have done the right thing in terms of drawing that line with respect to the pharmacists.

Mr Burrows: I think, as you heard Linda say yesterday, that there is really a double-edged issue here. One is, what is an appropriate set of criteria for title protection? The other issue is the one of trying to ensure there is not confusion in the public mind.

Mr Cordiano: That is exactly it.

Mr Burrows: To reiterate what Linda said yesterday, it comes down in some aspects to a judgement call. It was suggested in some of the discussions that we had as an aside yesterday that the one group that really has not been heard strongly on this issue is consumers. Are they or are they not confused and what would help them in that regard? It would seem to me that one of the things you might want to elicit from consumers who appear here is a response to that question.

Mr Cordiano: What was your information respecting that question, with the response from consumers? As an intended course of action before we came up with this list, did you sample the consumer to find out whether we are headed in the right direction?

Mr Burrows: Consumers were certainly involved at the association level in the review and we certainly had a lot of correspondence and dialogue since, not only with groups but with individual consumers. I think it is safe to say that this issue, in those discussions, has not been a focus of a large amount of discussion. The focus of discussion with consumers has been more on the broader issues, the complaints and discipline processes and so forth. So this may well be something the committee wants to go into in greater detail in this part of the process.

Mr Callahan: I just want to specifically ask why the government has moved an amendment to strike section 20 of Bill 61. Is that because pharmacists cannot delegate the delivery of drugs?

Ms Bohnen: No. With the clarification that any controlled act could be delegated, that is an amendment to the Health Professions Procedural Code. The regulation-making authority in each college was taken out of the individual

health profession act and moved to subsection 91(1) of the procedural code, paragraph 14.1.

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Mr Callahan: So that will be struck out of all the bills that deal with it.

Ms Bohnen: Yes, it was just shifted to the code. It was a little bit inconsistent in how it appeared in each health profession act.

Mr Callahan: If I could just quickly address my colleague's comment, if "doctor" could be used in a pharmacy where the consumer's major concern is to receive proper drug prescription preparation, would that not add to the impetus for various druggists to hire a doctor because it might be a marketing feature, and thereby add to the cost to the consumer? Maybe I should not ask you that. That is really a policy question.

The Chair: There will be an opportunity to ask those kinds of questions to the parliamentary assistant or to the minister when they are here.

Mr Callahan: I do not think it is a fair question.

Ms Bohnen: Could I just throw in one comment? As the registrar of the college pointed out, the scope of practice of pharmacy deals not just with the dispensing of drugs, but also the provision of information related to drug use. It may be that in the provision of information about drug use there is greater opportunity for a risk of confusion if the person is using the title "doctor" than there is in just the technical dispensing functioning per se.

Mr Callahan: I withdraw the other question. That really should not be put to you.

Mr White: I want to thank you for your explication as to why several fields were left alone in terms of the word "doctor"—doctor of psychology, doctor of medicine, doctor of chiropractic. That makes a good deal of sense. It is the entry level.

However, what I am concerned about is that within the health care disciplines, we have many very dedicated professionals who, though the entry level for their profession may be a bachelor's or a master's degree, are so dedicated that they are going back for further education. I think at an increasing level, if we allow only those people for whom the present entry level is a doctorate to refer to themselves in that way, in a sense we are preserving the status quo at a time when that status quo is moving. There is Dr Truong in pharmacy. I know many people who have doctorates in nursing or social work or whatever. They would not be able to refer to themselves by that name, even though they had earned those credentials.

I am wondering if you have any thoughts about perhaps limiting that phraseology and ensuring that people do not refer to themselves as doctors in medicine or doctors in psychology when they are clearly social workers, speech pathologists, whatever, as opposed to limiting the term entirely as an entry level.

Ms Bohnen: The options available to you, should the government wish to amend this provision of the bill, would be to consider provisions which permit the use of "doctor" together with a requirement that the nature of the

degree or the nature of the qualification be provided to the patient. You might consider that a rule like that is necessary for regulated, and perhaps a different rule, perhaps a different kind of prohibition concerned unregulated practitioners who may also have various kinds of doctorates, but who do not have a college to keep them to adhere to a particular set of rules.

I guess in the end you have to balance the desire to encourage professionals to advance their education against the public's need not to be confused about the practitioners they are dealing with.

Mr White: I think your suggestion makes a great deal of sense, but I think it will also, in terms of the public interest—if I were in need of mental health services and I had a choice between going to a social worker who had a bachelor's, a social worker with a master's and a social worker with a doctorate in social work, there is a slight change in terms of whether it is BSW, MSW or DSW. I probably would prefer the DSW. So in a sense there is a public interest there.

Ms Bohnen: There is a public interest. There is also the public interest in not encouraging credentialism that has an adverse impact on access to services. For example, if the general trend were to be that the entry level to practice—I will not name a profession—as whatever was advanced from a bachelor's to a master's or from a master's to a doctorate, you would have fewer practitioners available to the public. You have to be concerned about that. There could also be a negative impact on women, on immigrants, on rural Ontarians, on people who have difficulty accessing higher education.

Mr White: That is if the entry level were changed?

Ms Bohnen: Yes.

Mr Hope: I like the comment that was put forward earlier, that we are listening to the professional groups about this "doctor." I am looking forward to hearing the public and talking with them on this whole issue of "doctor." When I go to a doctor, the doctor—this is my own terminology—is one who will do an assessment on me and give me a diagnosis of what I have. We always say, "Well, how are things going, doc?"

The doctor I have in mind is going to be able to treat me. A doctor of pharmacy and stuff like that, I guess there is where the general public—the public, by the identification of "doctor," has to be assured that something hopefully will help their illness. I listened to the professionals express their point of view, but I think there is a group out there we have to keep in the back of our heads, the general public on their viewpoint on "doctor."

I just wanted to air that out, because I think you brought up a good point, listening to the public. What do they perceive as a doctor? What do they expect out of the word "doctor?" I think that is maybe where we should be going.

Mr Burrows: I think this is a perfect example of the validity of the title of the review's final report, Striking a New Balance. In its recommendations, it is our understanding in the ministry that this is what the review really tried to do on this issue, to expand the title protection slightly to incorporate a couple of groups that were not

previously protected but who widely used the title, but to draw the line there without broadening it so much as to make the title protection meaningless.

Certainly the option Linda mentioned is an option, but one of the downsides of that is that in those jurisdictions I think that may have such a model, where do you draw the line? It can become meaningless. There are diploma mills in existence where you can buy a degree of doctor of herbology, for example, that probably offers no protection whatsoever to the consumer. I could not agree more with your last statement, which is that if it comes down to a social call, certainly the people who need a voice here are the people who would access these services.

Mr Beer: Just briefly on your last point, I think the editorial this morning in the *Globe and Mail* would be useful, if people have not seen it. It speaks directly to herbalism and the case that has been before the courts, which is of interest.

The Chair: I have asked the research staff to circulate it to all members of the committee.

Mr Beer: I realize sometimes we get you back here and we are sort of bouncing back to different testimony, but I was concerned yesterday at the concerns raised by the disabled woman, I think in large part because that is not the way I have read the act here and also because I believe there are other things that are happening which provide protections or more meaningful programs for individuals.

To the best of your knowledge, did Mr Schwartz consult with the various disabled groups? Did the Ontario Advisory Council for Disabled Persons comment on this legislation? Are there a couple of real issues which may be presented to us later, but none the less which we should be trying to wrestle with in terms of Bill 43 or any of the others and the disabled community? That is the first thing.

Ms Bohnen: I do not recall that there was a great deal of consultation with the disabled community during the review, although the review was aware of the need to provide an exception for health services which might nevertheless be assistance with routines of daily living, and felt that there was sufficient flexibility in the system, with the exemption-granting power and so forth, to accommodate that. Subsequently there have been ongoing consultations between the Ministry of Health and the Ministry of Community and Social Services with groups such as Advocacy Resource Centre for the Handicapped and other government representatives concerned with these issues to discuss the nature of the exemption that would be helpful to them. Those discussions are continuing and are most recently involving the College of Nurses of Ontario and the Ontario Medical Association for their perspective.

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I guess the more difficult social policy issue that arises from this is whether there is a need to have different rules or different kinds of exemptions for individuals capable of directing their own attendant care and for those who are more vulnerable because of their mental or physical state who are not capable of self-directing; and second, whether there has to be detail that addresses an exemption for the more hazardous routines of daily living, things to do with ventilator care. It is largely because of the complexity of

these issues that it has been the preference of successive Health minister to iron out the details in a regulation rather than in the act.

Mr Beer: Thank you for that. Could I just note also for the record that it might be useful that we make contact with the Ontario advisory council and at some later date perhaps have the chairperson or others come. I recall very vividly, as Minister of Community and Social Services, this whole issue around the independence of the disabled community and how it is able to access these kinds of services. You have outlined it exactly and it is complex, but I would like to feel a greater comfort level around myself in terms of how we are approaching it. It may well be that the regulatory route is the way to go but frankly, I think there is a difference here over the last five years in terms of how we view those issues and how we are trying to deal with them. If I could just make a note that we would perhaps have them back later and if other groups come forward, this is something we might come back to.

The Chair: Is that a specific request, Mr Beer, for the group to be invited to the committee?

Mr Beer: One of the things I asked was whether they have put together any particular documentation, but if we did not get requests from the disabled community—I know there are some individuals, but I am just concerned that there is an issue here which—

The Chair: The clerk informs me there are two groups, she is trying to schedule here.

Mr Hope: Just to reaffirm what the ministry staff are saying about the disabled communities and attendant care, I know there is constant dialogue taking place around this whole issue and around the health professions regulations, making sure that the individuals out there wanting to live an independent life are able to live an independent life. I know, talking with the ministry people just yesterday, when the lady came and raised some concerns yesterday I got on the phone immediately to make sure this was happening. So there is dialogue going on and we are making sure the independence is still there.

Mr Beer: I quite realize that. I am not making this as a political point at all. As I said yesterday, I think this is something everybody has been moving towards. My concern was that here an individual came forward with concerns around the act which I thought were for the most part trying to be met in other ways, so I am concerned there may be some other issues out there among the disabled community and I think it is important that those get expressed here somehow.

Mr Martin: I just want to confirm Mr Beer's concern around that. I was not here yesterday to hear that. I wish I had been. It raised a red flag for me and if nothing else, certainly I would like at least a further briefing on it so I can get my head around it, know how to participate in the discussion more fully and support whatever we can do to make that happen.

The Chair: I have heard the request and there seems to be some agreement. I am sure Mr Wilson may want to make some comment on this but, at some point when we

have some time with the ministry officials, you might like some discussion on the impact of this legislation on the disabled individuals, what consultations have taken place and how, through regulation, you intend to ensure that the goals which have been expressed by all three caucuses are met. Can you spend some time or prepare some briefings for the committee on that?

Ms Bohnen: Sure, but it might be particularly useful to the committee to invite staff from the Ministry of Community and Social Services, since they administer attendant care programs. We have been working closely with them and involving them in discussions with community groups, so they are very knowledgeable about the impact. I can suggest to the clerk individuals who might be helpful.

The Chair: We can discuss the technicalities and how to do that but there seems to be a desire to have that happen at the committee. All agreed? The next speaker is Mr Wilson. I am going to hold supplementaries on issues to just one question, if it is a request that is really on the speakers' list.

Mr J. Wilson: I was wondering whether we could go back to the Ontario Chief Psychologists Association, where they recommend the amendment adding a "notwithstanding" clause. It was very close before I was cut off on the time limit. Could you comment on what they were trying to get at here?

Ms Bohnen: It is an option that has been considered together with other options in the ministry. I think they mean that the controlled act dealing with diagnosis would stay more or less as it is. Perhaps it could be easily improved upon but that would stay. Coupled with it would be an additional clause with words to the effect of, "Even though diagnosis is a controlled act, nevertheless a regulated health professional may assess his or her patient within his or her scope of practice and communicate the assessment to his or her patient." A number of regulated groups have recently proposed that as responding to their concerns. It just might be a little more difficult to apply that to unregulated groups that do not have any officially recognized scope of practice that their assessments could refer to, but it might be a solution for the regulated groups. I think that is what they meant.

Mr J. Wilson: I am glad you made the distinction between regulated and unregulated because I was thinking exactly that. When they come before us, this is not a remedy for their concerns.

Ms Bohnen: I think they may propose to you variations of that which they would see as a remedy for them.

Mr White: With the mental health clinics and hospitals there are some 4,000 social workers employed who are not regulated. I believe the total membership in the OPA is only around 700 or so. That kind of clause would not include the majority of the staff in mental health clinics who are social workers, so it would still limit that function, which I am sure is one of the major groups the psychologists were referring to.

Ms Bohnen: Yes, and social workers, although they are not currently regulated by statute, have a more definable

scope of practice than some of the other practitioner groups whom I think you will hear from who practise more outside. They do not practise so much in regulated settings like mental health centres, clinics and so on. I think you are correct in saying that solution would not do for them. It may be that variance of that solution would do for them, though.

1110

Ms Haeck: I have met with my local psychological group. One of the things they raised, which is sort of following up on some things that both Mr Wilson and Mr White have raised, was a concern that as a result of this act—I will use the figure "half"—half of their membership would no longer qualify to be part of their college.

Ms Bohnen: I had heard that very recently, however. I do not have the correspondence with me but it could probably be obtained. Their board of examiners in psychology wrote a letter of clarification to a member of the minister's staff saying that was not correct. I have forgotten the percentage they quoted but, according to the board, a very high proportion of psychologists do practise in what they regard as health care psychology.

Ms Haeck: Excuse me for interrupting. What would happen to those people who are in education?

Ms Bohnen: I would like to address that. The scope of practice of psychology is not restricted to hospital or medical clinic settings. It refers, for example, to the diagnosis of neuropsychological disorders and dysfunctions. It has always been our understanding that this scope of practice, which was negotiated with the review by this profession, included things like psycho-educational assessments, which is why diagnosing a child as having a particular learning disability would be within the controlled act of diagnosis. Our view has been that if the function refers to something within the scope of practice, there is not an issue here of regulation by the college. There are a smaller number of practitioners who practise industrial psychology, which is very far removed from health psychology. It has to do with things like industrial design, the design of driver licensing tests and things of that nature which are not, probably by any stretch as a term, health psychology.

Some of those practitioners are concerned that they would lose the benefit of the title protection. Nothing whatsoever would stop them from continuing to be registered with the college as psychologists. But since it is not held, by any stretch of the imagination—it is really not referred to in the scope of practice. This was the scope of practice agreed to by the profession. Their board now says the overwhelming majority of their registrants practise health psychology, so I think that issue has really narrowed in its significance.

Ms Haeck: I appreciate your comments.

Mr Callahan: I can raise my question the next time we have a break. It was to do with the investigation powers. I am just interested, if we can talk about that the next time.

The Chair: Any members of committee are free to pose questions informally at any time of the ministry staff, which they can respond to.

Mr Callahan: I think it is important to have on the record.

ONTARIO DIETETIC ASSOCIATION

The Chair: The next presentation is by the Ontario Dietetic Association. Please come forward. Welcome. I ask you to introduce yourselves. You have 20 minutes for your presentation. We ask also that you leave some time for questions if possible.

Mrs Poduch: Absolutely. Good morning. My name is Carol Poduch and I am president of the Ontario Dietetic Association. With me today are Mary Ann Rangam, who is the executive director for the Ontario Dietetic Association, and Phyllis Tanaka, who chairs our health professions legislation committee. There are two or three other delegates and interested listeners in the audience who are representing dietitians here today.

Dietitians are leaders in providing nutritional information to the public. The need for good nutrition information is common to each and every member of our population from infancy to old age. We are a profession with one foot firmly planted in the arena of disease prevention and health promotion while the other foot is firmly planted in the arena of disease intervention. You will find dietitians working in public health units, private practice, research, industry, school, throughout health care institutions and in many community settings. In fact, there are close to 2,000 dietitians practising in Ontario. It is well recognized that nutrition is a major component in the prevention of diseases and disorders. Some examples would include heart disease, cancer, diabetes and osteoporosis.

Members of the dietetic profession applaud this proposed legislation. The Ontario Dietetic Association strongly supports the legislation for its promotion of a health care system that provides protection to the public yet is innovative, cost-effective and safe.

The Regulated Health Professions Act respects the right to self-determination for both consumers and health professionals. The public will have the freedom to choose health care providers. Health professionals will be given the opportunity to improve the quality of the services they offer. These features should provide mutual benefit and facilitate the best outcome for all concerned.

In our view, the act can and should go further to protect the public interest. We have prepared five points for your consideration this morning. These points represent position statements of the Ontario Dietetic Association.

With respect to our first point dealing with controlled acts, we believe diagnosis should remain a controlled act. It is our belief, as is obviously held by many members of the committee, that there is a difference between diagnosis and assessment, and we too have grappled with what the definitions of "diagnosis" and "assessment" really are.

The conclusion we have come up with, with respect to assessment and diagnosis, is that health care providers contribute information gained from their assessment to the diagnostic process. While all regulated health care professionals can assess within their scope of practice, we feel that a limited number have the thorough knowledge base to assimilate all information and form a proper diagnosis

and treatment plan. Because it requires extensive knowledge, skill and practical experience to gather appropriate data and reach a conclusion regarding a patient's disease or disorder, this activity should be restricted to those health care providers thoroughly trained in the diagnostic process.

Consequently, our recommendation to the committee would be, first, that diagnosis remain a controlled act and second, to clarify some of the semantics, that there be definition of "diagnosis" included in the legislation.

Our second point deals with the harm clause. The harm clause, while possibly imperfect, we feel is necessary to protect the public from current and future risks that have not been anticipated by the Health Professions Procedural Code and the list of controlled acts. We feel the public deserves protection in two areas: first, from self-regulated health professionals who practise out of their scope of practice and, second, from unregulated health practitioners who provide treatments, some of which may not have been proven to be both safe and effective. It is our belief that the benefits in terms of public safety outweigh the risks associated with the potential for unintended use of this clause. Consequently, our recommendation would be to reintroduce the harm clause into the legislation.

The third point I would like to address this morning has to do with the scope-of-practice model. The ODA wants to use this time available to us to once again strongly support the basic premise of this legislation. The proposed scope-of-practice model encourages a working together of health care providers. This open and flexible system will foster professional growth and the creation of a comprehensive approach to patient care. We believe the outcome for consumers of health care services cannot help but be improved in terms of the development of innovative care programs that will have the benefit of input from a wide range of professional expertise. Our recommendation is essentially to maintain the scope-of-practice model. We feel it is a primary strength of the proposed legislation.

The fourth point I would like to raise this morning has to do with public membership on college councils. You are not going to believe this: We did not confer with the pharmacists prior to preparing our points this morning, but they are virtually identical. In the consultative process of developing the legislation, it was the general consensus that a one-third/two-thirds ratio struck a balance that allowed public protection under the self-regulatory model. Public members on the council will not have the knowledge of the profession to make informed decisions. Our perception is that the newly suggested ratio is out of balance, and our recommendation is to maintain lay membership at one third, as originally agreed upon.

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Our fifth and final point for the morning has to do with professional titles. One of the identified needs, after introduction of the Regulated Health Professions Act, has been for public education. Our feeling is that this is going to be no small task. To fully realize freedom of choice, we believe that consumers should be able to easily recognize health care providers that are regulated. Our members work in a variety of settings, yet have common educational and training backgrounds that entitle them to call themselves

dietitians. Job titles include both the term dietitian and/or nutritionist. We require protection of the professional designation "RD" and its French equivalent "DT." This is so that members of the public can easily identify members of the College of Dietitians of Ontario. Indeed, it is our feeling that title protection is the cornerstone of informed consent for the public.

Additionally, we feel that the holding-out section should be amended to protect the public from unscrupulous practitioners who may add descriptors to their titles in order to pass themselves off as regulated professionals. Consequently, our recommendations with respect to professional titles would be, first, to protect the professional designation "RD" and its equivalent "DT," and that the restricted-title section and holding-out section of the legislation should be amended to read "services in Ontario" and not just "health care services."

This concludes our formal presentation this morning, and I would like now to invite your questions.

Mr Owens: We have had some discussions around how consumers perceive various professionals. Coming from a hospital in my former life I know there was often confusion between the dietitian and the food service supervisor. What would your association propose doing with respect to promotion of the difference between your organization as a self-regulating body versus the food service supervisor who after two years of community college could come out and do her thing in the kitchen?

Mrs Poduch: Our association represents dietitians only. There is a different training background defined for dietitians versus food service supervisors. Dietitians hold a four-year baccalaureate degree in food and nutrition and subsequently complete an internship in dietetics. Our mission or our job as the ODA is really to represent dietitians. Presently, food service supervisors operate under a separate association in Ontario, so at this point in time it would not be our job to represent their interest.

Mr Owens: My question is more on how you would educate the public with respect to your role as dietitians so that confusion is eliminated.

Mrs Poduch: That is an issue we have not addressed in detail within our association. I can answer as it occurs to me at the moment, and that would be to represent ourselves with the training we have to the public, through the various media and outlets that will be available to us. It is important to dietitians to maintain our status as a part of the health care team, and that is probably where we would start, with direct consumers of our services, patients with the disorders I described—cancer, diabetes, osteoporosis. That would be our first step.

Mr J. Wilson: I was wondering about public membership on college councils. A few groups, as you know, have mentioned that now. Do you have any idea how the new rule came into effect or was suggested, that we have lay membership composed of just under 50%? Were you consulted on that at all?

Ms Tanaka: No, that decision for increasing the public participants was not part of the consultative process. That

was determined with the introduction of the bill under the new government.

Mr J. Wilson: If the minister's new suggestion were adopted by the committee, would that place any type of burden on you? I am just trying to get a feel for the concern.

Ms Tanaka: With our profession we will be a small college, so our governing council will not be a large governing council. For us, it will not necessarily place a burden in terms of numbers, making it too large a body. But as Carol mentioned, the public participating on the council provides a perspective in guiding policy development in health care but they do not necessarily have the knowledge base of the profession. We see that as the problem more than the actual numbers in our particular college.

Mr J. Wilson: I am glad to hear you say that, because my belief behind the new number is that it was basically a political decision. It sounds good to have almost half public on these. Having formerly been an executive assistant to our federal Minister of National Health and Welfare and trying to find some 2,700 people a year to fill appointments across Canada, I have no idea where the government is going to get all these qualified people.

Ms Tanaka: That is one of our concerns as well, the logistics of getting the public participants, having access to them, having public participants who can give up that amount of time and educating them in the process.

Mr J. Wilson: It does raise the cost. If the government moves ahead with just under 50% representation, as you understand it now, your college would have to absorb the cost of bringing these people up to speed. Would you be able to bear that cost? You would probably prefer not to, I would think.

Mrs Poduch: We are newly regulated, so it is very difficult for us to answer that. We have some sense of fear in anticipating trying to do that; concern with the logistics of effectively self-regulating and taking on that task as well.

Mr J. Wilson: My experience, too, with these is that unless you pay them a handsome per diem you have tremendous turnover on these councils. Certainly across Canada we were constantly replacing people and trying to bring them up to speed. I just throw that out so the government may consider that.

Mr Callahan: Perhaps I am opening up a can of worms, I do not know. I gather that dietitians do not cover the waterfront of things such as weight control, but I suspect that you may very well see the effects of some programs—I certainly would not want to zero in on any specific program—out there in the public domain that create a nutritional problem. Would that be a fair comment? Do you run into that?

Mrs Poduch: Create a nutritional problem?

Mr Callahan: You see all sorts of glitzy ads: "We'll take off 40 pounds in a day." I am sure none of that is healthy to the human body, but do you find any of that in your profession in terms of fitting into your mandate of nutrition, because they have gone to those who perhaps are not accurately describing what they can do for them?

Mrs Poduch: It is an issue we have dealt with over the years and it is a contentious issue for our association. There is no question about that. Our hope is that this legislation will help to protect the title "dietitian," and then we will be able to use that title to let the public know who we are and what we can do and that we have been recognized by the government of Ontario as having an expertise that is useful to them. In terms of protecting the public, that is an issue that needs to be dealt with. There is big business in weight loss. There is no question about that.

Mr Callahan: I am glad to hear you say that. That is something that down the road is perhaps another protection for consumers. Perhaps it is more appropriately dealt with through consumer legislation. I was curious as to whether you encountered that. As a professional dietitian that must create some problem.

Mrs Poduch: It is a problem. We would be happy to work with the government in that undertaking. We have very strong feelings about protecting the public in terms of fraudulent claims for weight loss as providing health care, and the 40-pounds-a-day example is classic. That does not provide adequate health care and does open up some risk in the long term.

Mr White: I have just a couple of very brief questions about your association. You referred to the difficulty you are faced with now, being a newly regulated profession. How large is your association?

Mrs Poduch: We have roughly 1,700 members of the ODA, and there are some members who will probably want to become members of the college who practice outside of the dietetic association, so that in total there are approximately 2,000 dietitians in Ontario.

1130

Mr White: So that is actually a fairly large association in terms of the parameters of the groups that we are looking at.

Mrs Poduch: Is it? I would not know.

Mr White: I would think so. What kind of problems do you anticipate in forming a college, a regulated, legally sanctioned institution?

Mrs Poduch: I think some of the concern we have is that it is all new to us and we have a learning curve to go through, and there is an anticipation of a major learning curve. Maybe some of our fears are unfounded, but it is this big, looming job to be done that we do not yet understand fully.

Mr White: I am sure you will have the resources.

Mr Hope: Dealing with the public membership of the council, I have heard the other viewpoint and then I hear the comments dealing with the public awareness of your job. Would it not make more sense, then, to have more of the professional group? You are talking about having more of the professional group on the council. Would it not be better to have more of the public involved in this council so that you are not hearing it from the professional or from the organization itself, but you are also hearing it from the public?

You are saying that you will not have the expertise around. Well, we all learn on a day-to-day basis, but I think it would be more important for you to have more

public perception inside the decision-making process, which then communicates your message, not just as a professional but as a public going out there and communicating that information.

Mrs Poduch: One of the points I wanted to raise earlier and was not able to was that we want to reiterate that we applaud the balance that was originally described and we are not interested in excluding the public from our activities. That is absolutely not what we want.

Our concern has more to do with the balance and the logistics of running the college. So let me reiterate clearly: We welcome input from the public. That has never been a question for us. It really has to do with logistics in working. That is a concern and perhaps a fear that we have.

Ms Haeck: I have just a very brief question and you are going to be expanding my learning curve by answering it. At the present time, how would you see getting the public representatives on to your college? Is that going to be done by your actually seeking them or are they all appointed by the province?

Ms Tanaka: My understanding at this point is that is going to be a government—

Ms Haeck: Each and every one will be a government appointee?

Ms Tanaka: I believe, from a briefing I attended last week that Minister Lankin conducted, they are in the process of developing a bureau of public participants. My understanding at this stage is that is where the public participants will be drawn from.

Ms Haeck: I know from my personal experience as being someone who was elected in September and then having a new process for public appointments, that my office has received a great many CVs of people who are interested in standing for government-appointed positions on a vast array of bodies. I really feel, unlike Mr Wilson, that in fact we are probably going to have a sea of faces from which to pick and people are very anxious to be part and parcel of the process. I think you are going to find that there are a lot of people who are interested in health care and want to participate.

The Chair: Thank you for your presentation.

Mr Callahan: Can I send you a couple of CVs?

Ms Haeck: Sure.

The Chair: We appreciate the representations that you have made to the committee and would advise you that if you have any further comments as the process unfolds, please feel free to communicate with us in writing at any time.

Mrs Poduch: Thank you very much. Good luck with your deliberations.

BEVERLY CAMPBELL

The Chair: The next presenter is Bev Campbell. Welcome to the standing committee on social development. You have 10 minutes for your presentation. While this is a formal committee, please feel quite comfortable in addressing it, and we would ask also that you leave a few minutes so that the committee can ask you some questions.

Ms Campbell: Thank you, Madam Chair and members of the committee. My name is Bev Campbell. I am a management consultant with a practice in downtown Toronto, and while I provide general management advisory services, my main interest these days is in employment equity. By training and experience I am a certified general accountant and a former professor of accounting and finance at George Brown College.

I am also a former member of the council of the College of Physicians and Surgeons of Ontario. I was appointed by order in council in April 1989 and served for two years until forced by the time demands of the position to resign two months ago. It is primarily the circumstances leading to that resignation, and their implications for public representation in the governance of health professions, that bring me here today.

As a secondary matter, I wish to raise for your consideration an issue which I believe is not adequately addressed in either the existing or the proposed new legislation, but is of concern to the young people of the province, as well as to people who are immigrating to Canada, and to Ontario in particular, with training acquired in other parts of the world. I refer to careers as health professionals, and in particular to the well-recognized and well-paid professions, such as medicine and dentistry.

With respect to public representation, my first issue, I would like to say that I support fully the proposals to increase substantially the numbers of lay members on councils. At the same time, I support the notion of self-regulation for responsible health professionals and therefore believe that the elected professional members of all councils should constitute the majority.

Speaking solely from my experience with the College of Physicians and Surgeons, I believe that increased lay membership is needed to:

(a) strengthen the public voice at council—and again from my own experience I can tell you that it is very difficult to stand and speak out in opposition to a quite overwhelming majority of professional members;

(b) to spread the committee work demands over more people, thus lightening the load for each, although in the proposed committee memberships for the CPSO in particular, there is increased public representation required;

(c) to provide greater diversity in the public perspective that is being brought to any issue.

This last need is one that concerns me and one which I fear will not be fulfilled unless the intertwined issues of exorbitant time demands and inequitable compensation are addressed.

As an example, in the 1990-91 year, I personally devoted 92 days to CPSO work. In addition, my fiduciary responsibilities and liabilities as a director were equal in all respects to those of a professional member of council. My compensation, by way of a per diem, was less than one fifth of the per diem compensation paid to a professional member. My experience, I believe, was typical of the demands on all public members of the CPSO council. I have attached to my presentation notes of a couple of documents, one of which is my own letter of resignation which sets out in

some detail the time demands in my experience and in the experience of one or two others, for your information.

Combining the substantial time demand with an inequitable compensation provision means that the pool of public members from which to draw will be restricted to those with considerable time available, such people as those who are retired or those who might be otherwise unemployed, as well as to those who are financially independent. While all of those views are important, I think the need for diverse perspectives representing the needs and concerns of us all will not be satisfied unless that situation is corrected.

1140

I urge you to take the opportunity provided by this legislative reform to provide accordingly. The contributions of business and professional people will be lost otherwise.

My comments with respect to access will be limited to the profession of medicine and the provisions of the code and Bill 55. I agree wholeheartedly that the consuming public must be able to rely on the profession to ensure that practitioners are properly qualified and remain up to date. Accordingly, the college is mandated to develop, establish and maintain standards of qualifications and of continuing competence.

The college's registration committee is mandated to rule on any application not meeting prescribed criteria for qualification, that is, from those applicants whose education and training were not acquired through recognized Canadian or US academic and internship programs; for example, obtained in Japan or Germany or Australia.

I believe that much more needs to be done to investigate and assess training programs around the world, in order to facilitate the entry of foreign-trained physicians, in particular, to practise in Ontario and throughout Canada. To this end I believe that there should be a stronger public voice on the registration committee than is currently proposed, which is two of seven members.

In summary, the issues of time demands and inequity in compensation for public members must be addressed to ensure broad public representation. Second, I urge you to address the issue of opening access to careers in the health care professions, in particular medicine.

I wish to commend the minister and her predecessors for their foresight and tenacity in bringing forth health-care legislation that I believe is a model for other jurisdictions to emulate.

I thank you for hearing my views. I would be quite happy to respond to questions.

Mr Hope: I have one in particular, dealing with the public representation on this, and I am glad you brought it out because I think a lot of us felt that way when we sat on boards, agencies or commissions.

In your own personal view, you commented that you had a hard time communicating, in getting the point of view across, of the public. Would increasing the size from the existing one third, which is the amendment, to just under half be more adequate in serving the needs and making sure the communication level of the public is brought into the professional group?

Ms Campbell: In my view, yes. Take the circumstances of the College of Physicians and Surgeons, for

example, which currently has a membership of 27, and that would likely change with the changes in the numbers of public members. There are currently six public members. You have to expect that there will be some diversity in the views and positions of the public members themselves. Hence, if all six members are in agreement on an issue, then probably six people acting together can help to convince 21 members, who are the rest of them, that this view ought to be respected. However, if only two or even one of those six holds a view strongly enough to pursue it, it is kind of difficult to get that through. I think increased numbers would add to the odds of there being more people of the public membership on side on a particular issue, and would add weight and support to communicating that concern to the rest of council.

Mr Hope: The issue you brought forward dealing with the per diem—and quite honestly, volunteer work is, as you know, getting costly. You talk about the differential between the professionals and the public sector. Where does that differential start? Who enforces the law and who brings in the per diem aspect of it? Is it the council itself, or is it—

Ms Campbell: With the public members, the rates are determined by the government through the regulations, I believe. The professional members' rates are determined by the colleges themselves. The determinations and the sources of payment are two different places. None the less, where they meet, the responsibilities and demands are equal, and that gives rise to a problem.

If I may go a step further, I recognize that public representation role is a volunteer role essentially, and no one would be expecting to spend full time doing that. There-

fore the issue of compensation is not substantial, provided that the time demand is constrained such that it is an appropriate percentage of one's normal time, and the kind of time that one could devote to volunteer activities.

The issue in this case is that the demands on the time, combined with the rate, make it very difficult. Nobody can devote 35% to 40% of their annual working time on a volunteer basis unless they are financially independent.

Mr Hope: Just to follow up on that point, I noticed you used 92 days of reference in a year's period. Say, for instance, there was a time period of allocated meetings scheduled, and if it went beyond that then you would be up for more per diems maybe, because you have been allocated a certain amount of time. You are saying that as issues arise in the public, or as issues arise in the council itself, it requires more meetings, so there should be a compensation. Say, for instance, there were fewer than 92 days; it was not a whole lot of financial hardship on yourself, it would not have been a problem. You probably would have stayed, but because it went beyond that point, it has now become harder for you financially.

Ms Campbell: That is exactly right, yes.

The Chair: Thank you very much for your presentation. We appreciate hearing from you. I know some of the members have signalled that they have questions. The amount of time for individuals was 10 minutes, and I am sure some of the members will want to have a chat with you following the meeting. The committee will reconvene at 2 pm.

The committee recessed at 1147.

AFTERNOON SITTING

The committee resumed at 1404.

TORONTO HOSPITAL
SPEECH AND SWALLOWING LABORATORY

The Vice-Chair: Order. Our first witness is from the Toronto Hospital speech and swallowing laboratory. Ruth Martin, come forward, please. Welcome to the committee, and you have 20 minutes for your presentation. I think it would be good to allow for some questions after your presentation, if that is your wish. Please proceed.

Dr R. Martin: I will not take the whole 20 minutes. I wish to thank the Chair and members of the committee for giving me the opportunity to address Bill 43 today. My name is Ruth Martin, and I am representing the Toronto Hospital speech and swallowing laboratory. This lab is operated by myself and Dr Scott Adams. Both of us hold PhDs; that is, doctoral degrees in speech pathology and speech science. Our group also includes three affiliate members, all faculty within the graduate department of speech pathology at the University of Toronto. These individuals also hold doctorates in speech pathology.

We work closely with a number of medical specialties, in particular, neurology, gastroenterology, and otolaryngology. Our mandate is threefold: We conduct research into the speech and swallowing disorders that often result from neurological damage, such as stroke and Parkinson's disease, we diagnose these speech and swallowing disorders, and we provide treatment to patients suffering from them. These three aspects of our work go hand in hand. That is, whenever we diagnose a patient's speech or swallowing function, we conduct a research study in parallel.

In our case, then, provision of health care goes beyond the traditional definition in that it includes both research and clinical practice. As such, Bill 43 could have far-reaching effects on both our direct patient care and our clinical research.

We wish to address the committee with regard to section 30 of Bill 43. This section of the legislation would restrict use of the title "doctor" to members of five colleges, the colleges of physicians and surgeons, dental surgeons, chiropractors, optometrists and psychologists. In effect, section 30 would prohibit individuals like ourselves, who hold earned doctorates in speech pathology, from using the title "doctor," and possibly the abbreviation "PhD," while providing health care in Ontario.

The members of our lab are very concerned with section 30 for the following reasons: First, after consulting with our national and provincial associations, we find no evidence that use of the title "doctor" by individuals holding PhDs in speech pathology has created confusion for patients in the past. In fact, we believe it is the patient's right to know the degree status of any individual providing health care.

In our case, a member of our lab, Dr Adams, by virtue of his PhD training, has specialized expertise in the speech disorders associated with Parkinson's disease. It was because of this training that the Toronto Hospital hired him

to establish the lab. By using the title "doctor" and the abbreviation "PhD," the public is made aware that this individual has specialized skills gained through several years of advanced training. The title "doctor" allows the patient to identify Dr Adams as a speech pathologist with specialized training.

Second, we believe section 30 will result in a situation that is fundamentally unfair and inconsistent. For example, under section 30, psychologists who hold PhDs will be referred to as "doctor," while speech pathologists with equivalent degrees will be restricted from using the title. This inconsistency is confusing and lacks justification.

Throughout the world and across Canada, persons with the degree of doctor of philosophy are referred to as doctor and PhD, and have been for many years. These titles are not reserved for PhDs within specific disciplines. To allow some, but not all PhD holders to use the title "doctor" will only create confusion for patients and the public. Thus, we suggest that section 30 is not consistent with the intent of Bill 43, which is to protect the health care consumer.

Finally section 30 will make it more difficult for us to establish our credibility with other members of the health care system. This is very important, because the future development of our lab hinges on our having the strong endorsement of our hospital administration, and strong collaborative ties with other health care providers, particularly those in medicine, dentistry, psychology and biomedical engineering. It will be very difficult for our profession to establish its credibility if our right to use the title "doctor" is removed.

For these reasons, we urge the committee to consider the many ramifications of section 30, both on the patient and the health care provider. It is our hope that the legislation can be modified such that health care professionals who hold doctorates will retain the right to identify themselves using the title "doctor."

1410

Ms Haeck: I had the opportunity to meet with someone at lunch regarding speech language pathology, and this issue was raised. I posed a question to that person, and I am also going to pose it to you at this time. The scenario this lady presented was that in her relations as part of the health care team and assessing someone who had a stroke, a neurologist would probably be involved, and she would be dealing with the manifestation, the speech problems as a result of that stroke. She felt her position would therefore be much more equal, because the neurologist would be referred to as Dr. So-and-so and she would be also referred to as Dr So-and-so by that patient, and therefore whatever her assessment or diagnosis of the patient and prescribed treatment would be dealt with in a very equitable manner.

My question to her then arose: What happens to all those people in this field who are part of the health care team in a hospital setting and who do not happen to have the doctor title, who are not PhDs? Do you feel that by virtue of not being a doctoral candidate they do not achieve the same credibility within the health care team?

Dr R. Martin: I think the two groups fulfil different roles. Any speech pathologist who has graduated from an accredited university program has fulfilled the requirements to practise speech pathology within the health care system. I practised speech pathology for several years with a master's degree before I went back and did my PhD.

A person who has gone back to school and done a PhD has spent four or five years training specifically to conduct research, and typically clinical research, then has specialized training in some field. In tertiary care facilities like the Toronto Hospital, it is very important that individuals with this specialized training are present so that if someone comes in, in our case, with Parkinson's disease and can benefit from the extended training of someone who has spent five years studying the speech manifestations of Parkinson's disease, then we can provide that service. There is a role in providing specialized service. There is a role for us in providing research skills that the person who has a master's degree in speech pathology may not have.

Ms Haack: I have a master's degree myself, and if I went for the doctorate in library science, yes, I would definitely like to have the PhD after my name, but I am not sure that every day of the week I would like to be Dr Haack. Somehow it has a different air to it. Christel works just fine most of the time. But I am concerned in light of the fact that there is a certain standard for entering the profession and that the professional standard for librarians and speech-language pathologists happens to be the master's degree. Are we setting up a criteria in this process that in fact is going to be exclusionary to the bulk of your membership?

Dr R. Martin: I do not think so for the reasons I mentioned a moment ago. I think there are different roles for both speech pathologists who have master's degrees and speech pathologists who have PhD training. The PhD is fundamentally a research degree. The reason it is important to have PhDs in the health care system today is that more and more the issue of quality assurance is coming up. It is not good enough to provide a health service, but it is necessary to determine if the service you are providing is making any difference. The only way to do that is to do some controlled research. With a PhD you have been trained to do that controlled research, and that is exactly what we do at the Toronto Hospital. We do it hand in hand with patient care. Whenever we diagnose a patient, that is diagnose the speech problem not his neurological problem, whenever we treat a patient, we do it within the context of a research study.

On the other hand, there is certainly room within the system, vast room and a need for speech pathologists to provide sound clinical service, diagnosis and treatment that is not necessarily within the scope of a full-scale research study of every patient.

Mr Beer: Thank you very much for your presentation. This question is one that has come up in our hearings this week on several occasions. One of the suggestions that may have been made by the review or by somebody, and I forget exactly but I think it may have been in the actual review, was that by way of regulation, for certain groups

that are practising within a hospital and perhaps certain other institutions that could be defined, one way to deal with this specific problem would be that there would be a regulation that would say that where a speech pathologist is working in a hospital, for example, he or she may use the term "doctor" if in fact he or she has the doctorate.

Have you or your organization looked at some of that? I suppose one of the distinctions is that if you went out into private practice, you would not be covered. I am assuming that probably the largest number of speech pathologists are in hospitals or working in institutions.

Dr R. Martin: I believe the largest number of speech pathologists in Ontario are actually working within the schools.

Mr Beer: With school boards; sorry.

Dr R. Martin: A large number of speech pathologists work within the health care system and many speech pathologists do private practice. It seems to me that the argument we have made for the person with PhD training being referred to as doctor and PhD holds not only if you are in a hospital, but if you are doing private practice, because presumably you are providing the same quality of care. You still have the doctoral training once you leave the hospital, and you should be recognized as such.

It is equally important for the public to be able to identify who has doctoral training and who does not outside the hospital as within the hospital, and maybe even more important. There are many signals to patients within the hospital as to who is a speech pathologist and who is an MD. At the Toronto Hospital my name badge would say "Ruth Martin, PhD" and underneath it "Speech Scientist, Speech Pathologist." It would have my picture, and it is colour-coded. MDs have a green badge; I have a red badge; nurses have a different colour of badge. So there are many indications as to who I am and who I am not.

Mr Beer: You are colour-coded.

Dr R. Martin: We are colour-coded, exactly.

Mr Beer: At the present time you are identified by PhD.

Dr R. Martin: On my name badge.

Mr Beer: Right, and in effect your area of specialization.

Dr R. Martin: Yes, as are the MDs, for example.

Mr Beer: Right.

Dr R. Martin: They would say, "John Smith, MD, Gastroenterology."

Mr Beer: What you are saying is that there is protection there. If a member of the public comes up to you, he knows what it is you do.

Dr R. Martin: That is right. At the same time, presently another individual, for example, an MD, would introduce me, as they typically do: "This is Dr Martin. She is a speech pathologist. She is going to do this."

Mr J. Wilson: In the case of Dr Adams, the current practice is that he would call himself on his name tag if it was the policy of the hospital, for instance, "Dr Adams," leave the PhD off, "Speech Pathologist," or whatever the actual title is underneath. Is that allowed in the current

legislation, do you know? Do you know what the legislative status is of titles right now?

Dr R. Martin: I do not know if it is allowed. I know it is not allowed at the Toronto Hospital.

Mr J. Wilson: We have had evidence before the committee that it is happening and it is my understanding, and I stand to be corrected by counsel, that it is currently within the Health Disciplines Act as really not permitted now either.

Dr R. Martin: I am not aware of the details of the present legislation. As I say, that is not the case at our hospital. I have spoken to people from various other hospitals in the city and I know the emphasis is always on making sure the patient knows who is who. For example, I spoke with people at Hugh MacMillan Rehabilitation Centre, and they have a similar name badge situation, the person's name, the degree status and specialty, not Dr So-and-so.

Mr J. Wilson: It is helpful the way the Toronto Hospital has it. That is the way I think the committee might consider standardizing for the rest of the province, because you do not use "Dr"; you are using the degree specification after the name, which I am sure is very helpful.

Dr R. Martin: That is, I guess, an issue somewhat separate from the issue of being able to identify yourself as "doctor."

Mr J. Wilson: In oral communication, for instance. Okay.

1420

The Vice-Chair: I have Mr Owens next.

Mr Owens: Thank you, Mr Chair—

The Vice-Chair: Mr Owens has some more questions. Doctor.

Dr R. Martin: Oh, okay. I am sorry.

The Vice-Chair: You have about three minutes left for those who would like to ask questions.

Mr Owens: I am a friendly person.

Dr R. Martin: I am sorry.

Mr Owens: You must know that I used to work at the Toronto Hospital, so you are running. Anyway, my question is along the same lines we have already heard. Do you find there is much confusion from patients with respect to the doctor identity? Do you find yourself having to explain the difference?

Dr R. Martin: I do not find I have to explain the difference, I assume because by 1991 speech pathologists have been a part of the health care system for some time now and people usually understand, generally, what it is that a speech pathologist does. When someone comes into our lab, it is very obvious that we are dealing only with the speech system, from the equipment they see around them, from the procedures we carry out, from what we talk about. We talk only about speech and language and issues related to that. Quite honestly, it is not a problem for us.

Also, can I just add that when a patient is seen at the Toronto Hospital, for example a patient with Parkinson's disease, he is seen by many different subspecialties, let us say, or specialties. I think it is fairly clear to the patient that

he is going from specialty to specialty, and that these are, to a certain extent, different and marked differently.

Mr Owens: In your opinion, then, consumer confusion would not be an issue if we agreed with your suggested amendment, and the amendment suggestions from other groups as well, that the title of "doctor" be more widely applied?

Dr R. Martin: In my experience, it has not been confusing in the past, and so I do not see why it would be confusing in the future.

Mr White: Does your regulatory body have standards in terms of the training for people who aspire to become speech pathologists?

Dr R. Martin: Yes. In order to be registered by the Ontario Association of Speech-Language Pathologists and Audiologists, one must have gone through certain training, but we do not have a college as of yet under this legislation.

Mr White: But you would anticipate having standards, in terms of what universities or faculties would be accredited to issue degrees in speech-language pathology.

Dr R. Martin: Yes, that is right.

Mr White: We have had the example before of, you know, Dr Cronkin Copps College of something or other, crobiology or whatever, being able to issue degrees or whatever, but you would have standards in terms of accreditation.

Dr R. Martin: Definitely. At the present time, in order to become a registered member of the Ontario association, you have to have gone through a program in speech pathology at an accredited school, and have done a certain number of clinical hours in several different subspecialties like children's language, adult neurogenic communication disorders, stuttering, hearing impairment, oral rehab and so on.

Mr White: You would have the same in terms of the doctoral degree?

Dr R. Martin: That is right. In order to earn a doctoral degree, you have to meet the standards of an accredited university, and that is established and maintained within the university system. So it is the university that grants me the degree, or that does not.

The Vice-Chair: Thank you very much for your presentation.

JAMES H. P. MAIN

The Vice-Chair: Moving right along, Dr James Main is next. Would you like to please come forward? It is Dr?

Dr Main: Yes.

The Vice-Chair: We have to keep our titles straight, especially in the context of the discussions around here. I think I should check my Bill 43 before we use that title. Welcome to the committee. You have a 10-minute presentation and you may wish to leave some time for questions. Please carry on.

Dr Main: I am here to speak on behalf of the faculty of dentistry of the University of Toronto. I am James Main, professor, and head of the department of oral pathology in the faculty of dentistry, professor of pathology in the faculty of medicine, and head of the dental department at Sunnybrook Health Science Centre.

The faculty wishes to comment on Bill 50, the act relating to denturists, and in particular to comment on the fact that this bill will permit denturists to make dentures for patients who have not been examined by a dentist. We believe this will result in cases of serious diseases of the mouth not being diagnosed until too late, with, in some cases anyway, serious health consequences for the patients.

When a patient is seen by a dentist, for any reason, the dentist will carry out a complete clinical examination of the mouth, jaws, jaw joints, salivary glands and face, and the dentist will take a medical history. He will then make a diagnoses, which is based on the findings of this examination, the medical history, and on the dentist's extensive knowledge of pathology, which is the science of diseases and disease processes.

There are very many diseases that can affect the mouth and the surrounding tissues, and to be able to diagnose these diseases requires a lot of study, a lot of reading and a great deal of clinical education. Dental students study pathology for three years, in the second, third and fourth years of the dental curriculum.

This provides them with a memory bank of knowledge of oral diseases, and also clinical experience in their diagnosis of these diseases, which is even more important in diagnosing early disease. This is the important time for diagnosis to be made from the point of view of the patient being able to be treated easily and effectively, and in terms of the serious diseases like cancer, curatively. In other words, with regard to the serious diseases, this is a matter of life or death. Cancer diagnosed early in the mouth, and treated at that time, is cured in the great majority of cases. Cancer diagnosed late is not cured. The patient dies.

Some of you may have seen the article in today's *Globe and Mail*, written by a patient who had a cancer of the bowel diagnosed by a physician at a routine checkup before he had any symptoms. This is a common situation also in the mouth, when cancers are diagnosed by dentists before the patients are aware they have them.

To illustrate this, I would like to show you four photographs. They are not gruesome, I hope, and are to illustrate the difficulty of early diagnoses of cancer and HIV infection.

This is the photograph of a patient's tongue with a huge cancer on it. Now this requires no diagnostic skill at all to recognize. Most lay people would recognize that as cancer, and to diagnose cancer at that stage is valueless. This patient is dead, as a result of that tumour. There is no virtue in it whatsoever.

This is also cancer, and that is just as deadly, but that is an early case. This is a lady in her mid-40s who has cancer in the middle of her upper lip. To most people, I am sure to the great majority of us, perhaps all, this would be looked on as a canker sore, or something relatively trivial, and not worth further investigation or even a great deal of thought.

This is cancer on the side of the tongue in a 26-year-old lady. Again, both this case and the previous case, were essentially asymptomatic. They had not troubled the patients in any way at all. They had not come to see their dentists about these lesions. They were picked up during routine examinations. In both these cases, the patients were referred to me at Sunnybrook to arrange for treatment.

The point I want to make is that unless you have a data bank in your brain of the diseases you are liable to see, you are not going to pay any attention to these. It is not only in regard to cancer that this argument applies. To illustrate another one, a gentleman who has the unequivocal signs of AIDS in his mouth was unaware of being HIV-infected, and he had no other symptoms whatsoever, but to trained persons who know what they are looking for, that is AIDS; it is not just an HIV infection. Once again, it was asymptomatic. It was not there because of this. To the great majority of people it would be passed over as a whitish tongue.

I could go on all afternoon showing you pictures of early disease of the mouth, all of which have been diagnosed, picked up by dentists and referred to me for further investigation or treatment, proving that they have been diagnosed and proving that they are in fact serious diseases, but I do not think there would be much point or perhaps even interest for you in such a thing.

As you know, denturists have no knowledge or training in pathology. Patients of the type I have shown would not be diagnosed by them and their diseases would progress unchecked. In some cases the delay would be fatal. The faculty has therefore asked me to express to you its opinion that the legislation should be amended so that before a denturist is allowed to construct dentures of any type, the patients should have been examined by a dentist. Thank you for your attention.

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Mr Beer: Thank you very much, Dr Main. I do not dispute anything you have shown us, but as we are obviously a group of laypeople without the specialty, a question comes to my mind on the ability of the denturist to figure out what the problem was in those cases where the person is going to the denturist for a plate or a denture. Why should the denturist necessarily have to know that? It is not as though he or she is making that diagnosis. The denturist is dealing with a person who needs a denture. I am just trying to find a relationship between other things he or she may know or which it perhaps would be helpful to know but—

Dr Main: The point is that when a patient goes to have his mouth examined, that person should have it examined by people who can recognize disease; otherwise the diseases are not going to be recognized. Making dentures is something that is done to replace lost tissues and so on. It has no direct relationship with diagnosis of disease.

There are occasions when denturists see patients and make dentures for them because the patients have been complaining about the dentures, and the complaint is in fact due to a disease process. For instance, the only personal experience I have of a denturist making an error of this sort is when I had a patient a number of years ago who had dentures made by a denturist because the previous denture had been uncomfortable, and so he said, "We'll make you new ones." He had done this, and the new ones were uncomfortable. The patient then went to the family physician, who referred him to me. The problem in this case was not a malignancy but a cyst. There was a cyst

under the denture. It was pressure from the cyst that was causing the denture to give rise to the symptoms, and making the new denture would not only not alleviated the symptoms, but had allowed the cyst to grow larger. A cyst is not a malignancy; it is not going to shorten the patient's life, but it is not a pleasant thing to have either and it could have been removed several months earlier when it was considerably smaller, had a proper diagnosis been made at that time.

Mr Beer: At the present time, not under this legislation but under what exists right now, a denturist can do a partial plate, a partial denture, is that right? But that has to be done at the direction of a dentist, or can that be done independently?

Dr Main: I am not terribly well informed on the legislation, to be honest, Mr Beer, but I know that under the new legislation they are not required to have the patients examined by anybody. They can just go ahead and treat them. We feel this government would be very ill advised to allow this to happen. They should be examined by somebody competent before dentures are made.

ROBERT KROLL

The Vice-Chair: We will move on to our next presenter, Robert Kroll, if you would like to come forward. Welcome to the committee. I remind you that you have 10 minutes.

Dr Kroll: I am going to bring you back to the PhD issue and in many ways my remarks echo those of Dr Martin's before me, so for those who still had some questions that were left unanswered, perhaps you could have a chance to talk about them now.

Thank you for allowing me this opportunity to discuss with you today my concerns about section 30 of Bill 43. By way of introduction, my name is Robert Kroll and I am head of the department of speech pathology at the Clarke Institute of Psychiatry, a position I have held for the past 17 years. I have a doctor of philosophy degree in speech pathology and have a cross-appointment to the University of Toronto.

When I first learned of this impending legislation through discussions with my colleagues and members of my professional association, I was very hard pressed to understand the reasoning and rationale behind it. I kept hearing that the purpose of the legislation, specifically the restriction on the use of the title "doctor," was meant to reduce confusion among the consumers of the health care system. To this day, I cannot comprehend how this would reduce confusion. As I understand it, the impending legislation would allow such professionals as physicians, psychologists, chiropractors, dentists and optometrists to use the title "doctor," while disallowing members of other clinical disciplines, such as speech-language pathology, pharmacy, nursing, audiology and so on to use similar titles. I feel this would result in legislated confusion rather than clarification of roles to the public. I also feel that the individual consumer's right to know the professional qualifications and degree status of the individual providing the service has been infringed upon if this legislation is approved.

The wording of this legislation implies to me that there are certain holders of doctorate degrees who appear to be more valuable or recognized than others. Is, for instance, a PhD in psychology more credible and more worthy of the title than a PhD in speech-language pathology? These are two clinical disciplines that have very similar academic tracks and holders of doctorate degrees within these two disciplines are constantly involved in independently assessing, diagnosing and prescribing methods of treatment for the various problems and disorders they see. Why does it seem fair or justified to allow the holder of a doctor of philosophy in psychology to call himself or herself "doctor," while disallowing the holder of a doctorate in speech-language pathology to call himself or herself by a similar title, when in fact training, education and clinical practice are very similar within these two disciplines?

I would like to describe for a moment my own workplace and the reason for my employer's decision to hire a PhD to lead the department of speech pathology. I work in concert with three other speech-language pathologists who hold masters' degrees. We provide specialized programming for people who have a variety of communication disorders and I guess we are noted for our treatment programs for children and adults who stutter.

I was hired specifically for my expertise in treatment outcome, research and in program development. Over the last 15 years we have been able to develop our programs, which we feel have ultimately been able to serve the needs of the community in a far more efficient way. I feel that this is in large part due to the decision made to hire a PhD to lead the department. From a consumer's point of view, the holder of this title also adds some credibility and comfort to the patients being served. The speech-language pathologists working in my department always have ready access to consult with me regarding difficult decisions around planning treatment programs for the various individuals they see.

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Furthermore, the patients themselves will have access to the department head, who currently holds the title "doctor," reflecting several years of advanced study in a specialty area. I do not hold the view that suddenly disallowing this individual to use his earned degree title will in any way benefit the consumer of our services. In the 17 years I have worked at the Clarke, I have never encountered any difficulty regarding titles or perceived patient confusion about the qualifications of the individuals working in my department.

I would also like to add that this legislation, if it is passed, will in fact infringe upon the right of academic institutions to define their standards of education and to grant the right to individuals to use the titles of their degrees. The PhD is the highest level of academic training that one can obtain. This legislation in Ontario would certainly prove to be a major disincentive for individuals accepting employment here. This is an extremely unfortunate situation since, as many of you may know or probably know, there is a sad shortage of qualified speech-language pathologists and services available to people with communication problems.

When highly trained specialists in speech-language pathology and audiology learn of these restrictions, it is unlikely that many would want to accept positions in Ontario. These additional shortages would create serious problems for health care delivery in speech-language pathology. We would end up seeing a dearth of clinical research. No longer would we have individuals working on program evaluation and treatment outcome studies, and it is my contention that this service to the public would be seriously affected since our clinicians would no longer have access to the research findings of the specialty workers. This situation would surely run contrary to the emphasis that has been placed on hospital quality assurance programs.

The PhD is a degree that is noted internationally and throughout the world holders of this degree are allowed to use the title "doctor," or the abbreviation "PhD" behind their names. I would urge the members of this standing committee to consider seriously the effects this intended legislation would have on the consumer, as well as on the practitioners within the affected fields. Ontario, as I have always known it, has been a forward-looking and socially aware province. I feel, though, that this intended legislation is a step in the backward direction and I hope we can look upon section 30 of Bill 43 as something that needs further study and major revision.

I would like to close my comments by illustrating the rather ambiguous and confusing nature of the impending legislation. As I mentioned at the beginning, I teach students both at the university and in the clinical teaching facility in which I work. Would I now be advised to counsel these students to refrain from calling me Dr Kroll as soon as they enter the Clarke Institute? Personally I think it is foolish to spend one's time dealing with these matters. As far as I am concerned, the issue of title usage, as it is presented in section 30, does not reflect the intended spirit of protection of the consumer of health care services in Ontario. I would therefore recommend expansion of the use of the title "doctor" to those health care professions offering doctorate programs. Thank you for your time and consideration.

The Vice-Chair: Thank you. We have but two minutes remaining and I call on Mr Martin, who was first on the list.

Mr Martin: Thank you for your presentation. Certainly the issue you raise is becoming one of some contention re this legislation and one that I think we certainly need to explore a little bit further.

We are getting differing opinions, depending on who is speaking, re the issue. The bottom line for me is that first of all I am led to believe that some of the rationale behind what is being done here is to try to lessen the level of in many instances somebody presenting themselves as a doctor is raising the expectation of the consumer that they are in fact getting a level of service that is of a quality. In some instances, that level of service is not being delivered and so there is some protection factor there.

There is also the issue of confusing the public. I am of the opinion that the public sometimes are not given enough

credit for figuring some of these things out by themselves. But the question I have—and there are two parts to it—is, will the dropping of the use of the term "doctor" for some of the groups here in fact lessen the type of service that will be delivered or can be delivered, and will the effort by the Ministry of Health to try to develop a team approach to delivery of services be positively or negatively affected by some people being doctors and others not?

Dr Kroll: Those of us who work here and continue to work here certainly abide by an ethical code and a standard of practice, and regardless of what the legislation ends up being, it certainly will not lessen any of the quality of service that we provide. Absolutely not.

But as I mentioned in my presentation, I think that the legislation may have far-reaching effects because it is so unique and so disheartening to up-and-coming researchers and specialists who may want to look to Ontario to continue or to develop their research and expertise. I think the effects would be long-term rather than immediate.

The Vice-Chair: I am sorry, we have run out of time. Thank you very much for your presentation.

DAVID G. SCROGGIE

The Vice-Chair: I would like to move on to our next presenter, David Scroggie. Please come forward and welcome to the committee. You have a total of 10 minutes. It is quite rushed, and if you would allow for some questions at the end of the presentation, if that is your wish.

Dr Scroggie: Thank you for allowing me to address you. I would like just to elaborate slightly on my qualifications. I graduated in medicine in 1964 and spent five years in general practice and then did my specialty training in psychiatry. Since then, for the past 15 years, I have worked half-time in a community mental health centre, first in the south Parkdale area and now up in the Lawrence-Dufferin area.

Since the blue book was published on the health review legislation, I have been involved with it concerning particularly the front-line workers and their ability to be able to continue their practice as I have seen them work, and I have great concerns that now under subsection 26(2) in the first controlled act that their ability to continue work without undue legal jeopardy would be quite compromised. So I would like to address that.

Diagnosis in physical medicine can be a well-defined and effective act, as it is based primarily on scientific evidence. It needs to be, as it is now, regulated in some way so as to protect the public from charlatans. However, diagnosis in the realm of mental health is a much less certain procedure. Medical practitioners have developed a diagnostic system but, as well, many professionals outside the physical medical field have developed a significant body of etiologic theory and effective practice. Both have contributed to and enhanced each other's knowledge, but many of the latter would be unregulated under the RHPA, and to protect their continued ability to practice without undue legal jeopardy, I strongly recommend that the following subsection, proposed by the Coalition of Unregulated Practitioners, be substituted for subsection 26(2):

Restrict unregulated and regulated in different ways: (1) retain the prohibition of practising medicine without a licence in relation to all the unregulated; (2) modify this prohibition in relation to the non-medical regulated professions by saying that it only applies if they perform a medically authorized controlled act for which they are not authorized; and (3) delete the first controlled act relying on the current prohibition of practising medicine without a licence in case of the unregulated, and introducing a new clause for all the regulated permitting them to communicate assessment within their scope of practice.

In addition, the advisory council should screen all prosecutions under the RHPA, except those initiated by a college in relation to its own members, setting aside those which do not pertain to the protection of the public.

To go on a little further and explain: In physical medicine, the scientific method has proven to be a potent tool in elucidating the nature of many diseases and allowing therefore for some powerful interventions producing cures or better control of the disease process. However, the proof of these methods has rested on demonstrated pathological changes in the normal basic cellular structure.

Unfortunately, for mental diseases, though researchers may be moving closer to this type of proof, with few exceptions this kind of hard scientific evidence is lacking. Consequently diagnosis is based on the clustering of similar observable signs and symptoms. The etiology or reasons for these remain in the realm of educated guesses or theories, of which many exist, and consequently so do proposed treatments.

However, there are physical medical conditions which do have psychic symptoms. The alert, honest non-medical practitioner must somehow be aware of these so the underlying medical condition can be properly attended to. Education, both for the practitioner and the client, is probably the best preventive. Unfortunately, these situations can slip by the awareness of even the best-trained medical personnel.

On the other hand, there are clearly mental health issues which are never going to have a demonstrated physical cause. Most marital/family conflicts do not. Sexual abuse, while it is a physical act, has devastating psychological effects but no physical brain pathology. Indeed, most of the experts in these two fields are not physicians but unregulated social workers and family therapists. Are they going to be prevented from naming the dysfunction or disorder which they perceive from their extensive training to be the cause of a family's stress, or a sexual abuse victim's emotional problems?

Certainly in the realm of mental health, psychiatrists and registered psychologists do not have the corner on the diagnostic truth market. All disciplines interpenetrate and enrich each other.

Briefly, I have tried to demonstrate the impossibility of keeping the diagnosis in the mental health field strictly a medical act and therefore controlled as it is presently proposed. I believe that the way through this dilemma and to protect adequately both the public and the unregulated practitioner is by adopting the solution as outlined in the above summary.

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Mr White: I find the examples interesting. I have had a fairly extensive background myself as a family and child therapist, and in terms of the area of sexual abuse have worked extensively with adults who were molested as children, primarily women. It certainly has devastating psychological effects some of which have physiological ramifications, high levels of anxiety, depression, etc.

I think you are quite accurate on this point, but with this legislation, without being able to make that kind of assessment we would essentially be colluding with the continued suppression of that kind of abuse, at least within the clinical realm.

Dr Scroggie: That is a possibility, but it seems to me it does not make sense because—I am not sure of your background—my awareness is that most of the front-line workers dealing in that area say, "I am not a psychiatrist or a registered psychologist," so that if they could not make the assessment and give their opinion, then the health services would be overloaded. They are overloaded now and I do not know how the health system would continue to function, frankly, unless somehow you get around this dilemma of allowing assessments to be made by non-regulated professionals.

Mr White: Or professions which are presently non-regulated, such as family therapists and social workers that you specify.

Dr Scroggie: I think the whole system would—I know the intent of the legislation is not that, but I think the effect would be and certainly people in the field feel it would be. This is my great concern.

Mr Beer: You have suggested that we look at what the Coalition of Unregulated Practitioners has put forward. I know we are going to hear from them and they have submitted some written material.

In terms of that in relation to the old harm clause, what is your sense of the way of dealing with the problem, which I think I understand as you set it out? Do you think there should be a harm clause as set out before? Is that another way of trying to deal with this same issue?

One of the issues that has been raised with us would be the third part on page 2, where it talks about permitting each profession to communicate assessments within its scope of practice, which is clearly one of the problems that people see. On the balance, can the problems that have been raised here be dealt with by some new harm clause, or do you feel it needs to be this specific with regard to the way it has been worded?

Dr Scroggie: It is a very difficult issue. My initial concern and involvement was over the harm clause, which I felt was even more draconian than perhaps this is. I think it would really even be a wetter blanket than this would be in terms of preventing people from engaging in legitimate practice.

Take your sexual abuse situation: As you get involved in dealing with these people, you take off a layer and another layer and it gets very concerning because more and more memories come up and you have no idea what might occur in terms of their feelings and reactions to

those feelings. You certainly do not want to cause harm, but on the other hand, in dealing with them that might be a consequence of doing effective therapy—not intentionally, but there is certainly a possibility. I think this kind of situation needs to be protected.

I know the original committee on this certainly was against continuing the clause about the practice of medicine. At least you are dealing with something that is fairly specific, and once you move off that you get into a very non-specific area. I guess my feeling was that by retaining that at least you would have something harder to deal with, and if further research develops harder criteria in the psychological area, then you can sort of add on when you know there are more clear facts and details involved.

The Chair: Thank you for your presentation.

Dr Scroggie: Thank you for the opportunity.

DEANNA MULVIHILL

The Chair: Deanna Mulvihill. Welcome. You have 10 minutes for your presentation and we would ask, if you can, to leave some time at the end for questions from members of the committee.

Ms Mulvihill: I thank the Chairman and the members of the committee for hearing me. By way of introduction, my name is Deanna Mulvihill. I am speaking here as an individual nurse. I am presently employed as the director of nursing practice at the Hospital for Sick Children, and in that position I have a joint appointment at the University of Toronto.

In reviewing the act, I actually like many aspects and approve of many aspects in the act and welcome its introduction as a participatory collaborative practice to delivery of health care, but I did have some concerns and I have listed them for you.

Under clause 8(b) in relationship to the membership of the advisory council, you are exempting people who are or have been members of their council or college. Although I can see that there may be a conflict of interest if someone is presently a member of their own college. I come with 25 years' or more experience in the health care field, and if I had been a member of my college 10 years ago I could only see that would add to me as a member of the advisory council at some later date. So to me, that did not quite make sense.

The other issues I have heard already spoken about today, so I will not spend a length of time on them. The first one has to do with communicating to the individual his or her personal representative a conclusion identifying from disease. You have heard several presentations, but I would like to speak to the issue in relationship to nursing diagnosis.

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Nursing, as many people are not aware, is a distinct discipline from medicine, and we have a distinct scope of practice in that nursing as a scope of practice helps individuals cope with their handling of the disease process. So many factors deal with the prevention, coping and lifestyle assessment.

I have attached the characteristics of nursing diagnosis and I have also attached some ways nurses have of classifying their diagnosis. So you can see that in no way would we want to be sharing the medical diagnosis with the person but looking at how this impacts on their lifestyle, their relationships and how they are coping with the disease.

In relationship to your comment, Mr Beer, to our last speaker, I think one of the things that would help nurses in using nursing diagnosis is that we could begin to do some research on which interventions helped. Nursing is a very soft science and we have not had a long history of doing research. We are struggling with trying to do that now, but when we get into not analysing or labelling our problems in a consistent fashion, that does not give us a good background of research in which we can move our profession forward. That was one area I wanted to address.

The next one is, of course, the title of "doctor," and I really will not belabour that point because I have heard a number of speakers there. I really feel that perhaps the intent was to help the public with confusion. I am presenting myself as a nurse. In no way does restricting the title of "doctor" to certain people eliminate the confusion between who is a doctor and who is a physician, and there is no way, if I would present myself as a doctor, I would want to be presenting myself as a physician.

Schedule 2, which is my next point on the paper, is that there is information that you are saying the college or the councils would give out on people. There have been problems in the past where the college—and presently the college does give out nurses' home addresses and telephone numbers. This, particularly for some nurses who work in high-risk areas, has presented them and put them many times in a personal risk situation. There is no way anyone other than I should be giving out my home telephone and address, and there have been many risk issues.

Section 85, under schedule 2, is the limitation period of one year. I do not feel this is appropriate in many cases, and the college needs to be aware of all areas of negligence and malpractice and not restrict it to one year. Each case then has to be validated or assessed on its individual basis; what relevance it has to the practice of the practitioner at that point in time.

My last note has to do with procedures and methods regarding the investigation, hearing and evaluation of sexual abuse and sexual impropriety and the need to have their own unique process, separate and different from other malpractice things. I have made some suggestions: that there be a period of preliminary investigation prior to the notification of the physician; seizure of appropriate medical records at the same moment of physician identification; that the physician be allowed to retain a copy in order to prepare his or her defence; that there be early notification and involvement of the police in a joint investigation; the removal of the physician from patient care during the investigation procedure; protection of the identity of the patients by closed-court system and media blackout; and that the time period from the initial complaint to the discipline hearing not exceed six months.

I also suggest the Limitations Act be amended immediately, in keeping with the March 1991 report of the Limitations Act

consulting group, so that there be no limitation period whatsoever on sexual assault occurring in or as a result of a relationship of authority, trust or dependency, and that the offence of aggravated sexual assault in the Criminal Code be amended to include "by a person in a position of trust or authority."

Mr Owens: Ms Mulvihill, that was an excellent presentation and I think you will find sympathy among the committee members for the issues you raise, especially the last issue with respect to sexual abuse. The issues you have raised notwithstanding, do you find this piece of legislation will follow the intent of the government, which is clearly to provide consumers with a wider choice of health care services, but also adding that extra level of protection consumers need and want?

Ms Mulvihill: Yes, I do. Not only does it offer many things for the consumer, but it also offers a more collaborative practice for the variety of disciplines and I welcome the recognition of those other disciplines into a joint presentation. I think it paves the pathway for eventually a more collaborative health care service than I feel we have been in, which is a more heavily medical service and illness-oriented service.

The Chair: Thank you very much for your presentation.

MARY ANNE WITZEL

The Chair: Mary Anne Witzel, welcome to the standing committee on social development. You have 10 minutes for your presentation and we would like to leave some time for questions.

Dr Witzel: Thank you, Madam Chair and members of the standing committee on social development, for giving me the opportunity to speak to you. I am the director of the department of Speech-Language Pathology at the Hospital for Sick Children and hold appointments in the faculty of medicine, faculty of dentistry and school of graduate studies at the University of Toronto. I have a PhD in speech pathology and I specialize in assessment, diagnosis and treatment of patients with cleft palate and facial deformity. I am here today as a member of the Alliance for Equal Entitlement in Health Care and also as a member of the Ontario Association of Speech-Language Pathologists and Audiologists to again voice concerns about section 30 of Bill 43.

Section 30 restricts the use of the title "doctor," a variation or abbreviation, which to me means the letters PhD, or an equivalent in another language, in the course of providing or offering to provide in Ontario health care to individuals to members of the colleges of chiropractors, optometrists, physicians and surgeons, psychologists and dental surgeons.

Ladies and gentlemen, we are proposing that you support and recommend changes to section 30 that would continue to allow health care professionals such as speech-language pathologists trained at the doctorate level to use the title "doctor." As it currently stands, section 30 is unfair and unjust to both the public and health care professionals for the following reasons: It legislates confusion for the public; it removes the public's right to know

the qualifications of some health care professionals; it legislates and reinforces gender biases in the health care system; it is a disincentive to excellence in health care in Ontario.

With regard to my first point, it legislates confusion for patients and the public. Ms Lindberg, assistant deputy minister, consumer health and planning, stated in a letter to my MPP, Mr Marchese, July 15 that the "purpose of the proposed restrictions is solely to assist consumers to distinguish among health providers." But how is the public to know which professional with a PhD they may call doctor and which ones they may not?

Picture this common scenario at the Hospital for Sick Children: A PhD psychologist and a PhD speech-language pathologist working in a teaching hospital are meeting jointly with the parents of a child with psychological and speech and language problems to discuss test findings and treatment. In attendance, because it is a teaching hospital, is a student in speech-language pathology and a medical resident from the University of Toronto. The student and medical resident would address both professionals with the title "doctor," because they are not giving them health care, yet the parents would have to be instructed that they can only use the title "doctor" when addressing the psychologist, but not the speech pathologist. Would it not be natural for the parent to react with confusion, to have more trust and credence in the psychologist's opinions? Would the student and medical resident not also experience confusion? One minute the speech-language pathologist is a doctor and the next minute she is not.

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2. It removes the public's right to know the qualifications of all of their health care providers. Patients have this right. I want it as a patient. It enables them to make more informed decisions about their own health care. The patient's right to know is supported in the codes of ethics of the Ontario and Canadian associations of speech-language pathology and audiology, which state that "members must not misrepresent their training or competence" to the public. If we are unable to use the title "doctor," a variation or abbreviation, how are we truthfully to represent our training and competence to the public? Are we to remove our diplomas from the walls of our offices? Are we to drop our PhD credentials from our name badges, from our letterhead? Speech-language pathologists and audiologists who have sought training at the doctorate level often provide health care in a very specialized area; for example, Dr Kroll in stuttering and Dr Martin in swallowing problems and myself in cleft palate and craniofacial deformities. These are difficult and complex disorders and to our patients the PhD and its title "doctor" is often a further assurance of quality of care.

3. It legislates and reinforces gender biases in the health care system. Frances Lankin, Minister of Health, in her opening statement on August 6 regarding the Regulated Health Professions Act stated, "This legislation brings women closer to achieving equality in a health care system that has been dominated by men." However, with the exception of psychology, whose membership is approximately 50% female, the professions which will be

allowed to use the title "doctor" under section 30 are male-dominated professions. Those that will be precluded, such as speech-language pathology, audiology, nursing, physiotherapy, are female-dominated professions.

Unchanged, section 30 will result in a further entrenchment of the gender biases which presently exist in the health care system. This differential treatment of female- and male-dominated health professions calls to question the most basic tenets of equality and sends a clear message that the government of Ontario does not really support equality in the health care system, but rather gender bias. Therefore I submit to you that section 30 does not bring women closer to achieving equality in the health care system; rather, it moves them farther away.

Section 39 of the act states that, "Subject to the approval of the Lieutenant Governor in Council, the minister may make regulations allowing the use of the title 'doctor.'" But why, ladies and gentlemen, must we with doctorates in the female-dominated health professions be required to apply for use of our rightful title through the back door?

It is a disincentive to excellence and leadership in health care in Ontario. Unchanged, section 30 will cause Ontario to be the only province in Canada, the only place in the world, where an individual with a PhD in health professions other than psychology cannot rightfully use the title "doctor" in providing health care. This legislation will discourage the health care professionals of tomorrow from seeking advanced training in professions such as speech-language pathology and audiology. It will discourage these individuals from providing health care in Ontario, from offering specialty knowledge in the more complex areas of communication and hearing problems to the people of Ontario and from providing leadership, teaching and research in the profession.

Ontario has a right to be proud of the contribution its PhD members of the professions of speech-language pathology and audiology have made to the diagnosis and treatment of communication and hearing problems. Many have brought international recognition to this province in the practice of speech-language pathology and audiology. The province should be supportive of these individuals and not treat them as second-class health care professionals.

In closing, I urge you on behalf of my PhD colleagues to amend section 30, for it does not assist consumers to distinguish among health providers, but rather, it legislates confusion for the public. It removes the public's right to know the qualifications of all of their health care providers. It legislates and reinforces gender biases between health care providers and discourages excellence in the health care system of Ontario. We ask that section 30 be amended to expand the use of the title "doctor" to those health care professions offering doctoral programs. Thank you.

The Chair: Thank you very much for your presentation.

Mr J. Wilson: Can we ask a question?

The Chair: We have used all the time.

CENTRE FOR INDEPENDENT LIVING IN TORONTO INC.

The Chair: We are now going to hear from Mr Victor R. Willi, who is representing the Centre for Independent Living in Toronto Inc. Welcome, Mr Willi. You have 20 minutes for your presentation, and I would alert members to the fact that you also have a video which is available from the clerk's office if any member wishes to view it. We would ask that you leave some time so that members can ask questions at the end of your presentation, but it is your decision as to whether you wish to do that.

Mr Willi: My purpose in appearing before this committee is to explain why the inclusion of attendant services in Bill 43 will destroy 30 years of struggle by people with disabilities for the right to live in the community.

I speak to you today as a member of the independent living movement, which is really part of a social movement spreading across the world. It consists of people with disabilities taking responsibility for their own lives. We have been called the last civil rights movement. Years after black people have forgotten what it was like to ride at the back of the bus, we are fighting to get on the bus; and while the women's movement pushes for equal representation in the boardrooms, we struggle to find work.

Although there is archaeological evidence indicating that people with disabilities were fully integrated in prehistoric times, throughout most of recorded history we were institutionalized and taken care of by others. The two most popular methods of service delivery to us in the western world today are still based on either the welfare or the medical model of disability. In the former, others decide who deserves the service; in the latter, others decide what is best for the individual.

Both these methods have their place, but people striving to live independently in the community are neither in need of charity nor sick. They require individual responsibility for directing their own services and their own lives. That includes having the dignity of risk taken for granted by the rest of society.

It was out of this need that—and I am giving you a little background to show you why the inclusion of attendant services in that bill is of critical importance to us—in the early 1960s, people with disabilities first formulated the principles of independent living in general, and attendant services in particular. These have worked so well for us that they are almost sacred. After hundreds of years of well-intentioned institutionalization and segregation, we have found something that works for us. I will attempt to explain why.

Attendant services are almost universally misunderstood. My own family has a very hard time understanding that I am not taken care of. Even the term "attendant care" is a misnomer. The attendant's job is not to care. The responsibility for directing and training attendants rests squarely with the consumer of the service. The locus of control is with the consumer. This is a unique relationship. I do not think anything exactly like it exists anywhere, and that is why it is difficult for the average lay person to be familiar with it. But it is critical to understand that it is a

real alternative to the dependency-inducing medical and professional models where experts take all the responsibility.

The consumer—myself—is the expert because all of us are experts in our own needs and wants. I am not talking about fancy lifestyles here. This is about how and when people go to the washroom. It is about how something like what you are wearing today is important for you, and why it was important you chose that particular tie or skirt or whatever. It is how people look after their most basic routines, which can include eating, cleaning your own ears, and for women, inserting a tampon.

The controlled acts set out in section 26 would medicalize, and in some cases, make illegal, what most of us consider a normal daily routine. So what, if we really have to ask others to assist us in the community and to help us with our daily routine? Is that not what society is all about? People helping other people so that we can contribute to society?

Yet section 26—and I am speaking for people with disabilities who use attendant services—would make most of our daily ways of coping with disability an illegal, dangerous, or at best, a controlled act.

1520

What I am trying to say here is that people with disabilities themselves have come up with what is really a low-tech solution to an incredible institution, in other words, the health services system. I must tell you, this is a grass-roots sort of thing. Many of the arguments that are used against giving people with disabilities a chance to control their own services, to run their own lives, protecting us from risk and making decisions, are the very same arguments that were used earlier against minorities and, not too long ago, against women, in not allowing them access to the levers of control and decision-making in society. It is not that long ago that women were not allowed to vote and do many things.

We draw very much from the civil rights movement. There are many parallels. That is why I am trying to familiarize you with it in a way that you can understand.

The offer of a special regulation is well-intentioned but potentially harmful and somewhat patronizing. It is mistakenly aimed at the attendant, completely ignoring the responsibility and control of the consumer. Also, a future minister could do away with it at the stroke of a pen.

This is a matter where the public interest is at stake. I am sure the intention in writing this act was to do no harm; in fact, it was to remove harm from receivers of health care. But this very fact is what could happen if attendant services are allowed to remain in this act.

At this moment there are about 2,000 people with disabilities in Ontario directing some 3,000 attendants. I have lived independently for the past 16 years using attendant services and I have lived with a disability for 25 years. I work full-time and I pay an obscene amount of taxes, but I am proud to be able to this.

The attendant services I receive are, I feel, among the best in the western world. The cost per diem is extremely low considering we are talking in Ontario right now about daily services to a population bigger than the entire patient population of Toronto General Hospital; and I am sure

many of you here are familiar with the annual budget of Toronto General Hospital. At the very most, we are talking about a cost per diem per individual which is less than 10% of the cost of someone being in the hospital.

It also appears that there will be a dramatic increase in the number of people living in the community in need of these daily support services. I am alluding to the policy statements of this government and the previous two governments regarding the idea of helping people get out in the community, get out of institutions, and become useful contributing citizens.

There really is and has been and continues to be an irrational resistance to the understanding of this concept and the embracing of it as it should be. I do not understand why. We feel, after trying to sell this concept to the government and to social services for the past 15 years, a tremendous resistance, especially on the part of the health professions. Now, I do not know if this is a turf struggle, or is perceived as a turf struggle or as a threat to control, but somehow this act has cast a huge net over all of us with disabilities, when we have just had our first 15 years of progress.

The first sort of niche we made was in 1975 when we convinced the Ministry of Consumer and Social Services to fund a project, as I understand it, that people themselves had set up and were supporting with their WCB cheques or UIC cheques and their FBA disability benefits. It is still running to this day.

Before this legislation proceeds any further, I request you to help us correct a serious mistake in an otherwise laudable piece of legislation. Make an exception for attendant services in the act itself and recognize it as a unique and empowering option of service delivery for people who can direct their own services.

We propose an exception under clause 28(e) reading something like "working as an attendant providing physical assistance to a person with a physical disability, under the direction of such person and the act is a controlled act set out in paragraph 5 or 6 of subsection 26(2)."

Tomorrow my colleagues and I will be meeting with the Ontario Medical Association and quite possibly the Ontario Nurses' Association and their lawyers to try to work out the precise wording acceptable to both of us—the consumer and professional groups—for insertion into the act. This will be presented to you on August 28 by Ian Parker of the Attendant Care Action Coalition, better known as ACAC.

I have included background information in the form of a paper and a video on attendant services. The video is really an updated version of one that was aired last year following a conference we had on attendant services. At one part in the video one of the honourable members of the committee is featured. If you choose to look at the video, there are some blank spots which will be filled in by commercials prior to its airing on CBC. It is an updated version of how we are doing in this fight.

In the coming weeks you will be hearing from other people with disabilities regarding Bill 43. You may be surprised at the depth of feeling and anger occasionally displayed, but I want you to consider this: After 20 years of

explaining ourselves, explaining why it is important we live in the community, why we should use public transit or enter public buildings, explaining why we want to have children, get married, we find ourselves at this juncture in 1991 explaining why it is important that we control how and why and when we go to the washroom.

I urge this committee to give us serious consideration and I thank each one of you for hearing me out. I would be glad to answer any questions you may have.

Mr Hope: It is good to see you again, Victor. I know you are concentrating on certain sections but, dealing with the disabled community in finding adequate service providers or finding service treatment, as we start to identify the criteria of certain legislative body groups, that service may not be so difficult because you talked about how you have moved yourself up, and you have probably met some people who were providing non-adequate service. Did you find that the legislation has, outside of the issue you are talking about—which means it would be looked into more deeply—outside of that issue, would it not be easier and maybe better for the disabled community in identifying—

Mr Willi: What I am trying to say is that this attendant service is completely outside the sphere of medical health services per se, although it usually ends up in a ministry that deals with these other issues. Including the attendant services in there would drive it back into that again. We are completely outside that.

People receiving attendant care train their own attendants. You cannot get an attendant. When attendants from agencies occasionally have to be called if the regular attendant does not show up, people just simply do not go to bed until they leave. You develop a very personal, unique relationship with the attendant and there is a sort of interplay back and forth. The person with the disability trains the individual in the routine and then directs what is needed at a particular time.

We access the health care system as much as or maybe more than anybody else. These people are outside that and we would like to be exempted in the same way. These are our homes, these are things that happen in our homes. Just as the care givers in the home were exempted, we would like that same sort of exemption.

Mr Hope: What you are saying is that the Victorian Order of Nurses who supply home services may be going that same route, looking for exemption because they provide care in a home setting?

Mr Willi: Well, VON helps sick people. They give needles to people who are diabetic and who cannot give their own needles, they do medical procedures. We are not dealing with medical procedures. Going to the washroom is not a medical procedure. I have been doing that for 25 years with the help of other people with no problems whatsoever. I think there is the implication that some of these acts are dangerous.

I should make it clear that I am talking about people who have the ability to direct their own services. The onus is always on you when you are disabled to prove you are not incompetent, and it is the other way around if you are

not. That just goes with the territory. That is something else we have to fight.

We see the implication in here, that when disabled people, regardless of their cognitive level, direct their own services and direct people to do this, somehow you say, "It'll be a little dangerous, you know." I hope I am answering your question.

Mr Hope: Oh, you are.

1530

Mr Beer: Nice to see you again as well.

Mr Willi: Good to be here.

Mr Beer: In the description of the prohibitions under 26, they talk about, "No person shall perform a controlled act set out in subsection (2) in the course of providing health care services." I agree completely with the premise that in terms of you dealing with the individual who is attending you, that direction comes from you and you set it out. I think most of us would say those are what I would describe as daily sorts of services or functions.

I am really interested in the fact you are sitting down with the OMA, and I think the committee would be very much interested in the sorts of things you come up with there. But is there a way, and I guess I throw this out as a possible suggestion as you are meeting with people from the OMA, of defining the attendant care services or the meaning here of health care services so that, clearly, what is being done under the attendant care program, however you want to describe it, is not health care? Or is your feeling that, because we are getting more and more sophisticated with providing those services, while perhaps 90% of them could not in any way be described as health care, eventually indeed some things may be able to be done, just because of the advance of technology or whatever, or when we get into things like perhaps certain kinds of drugs that may be being provided to that individual.

I guess it is just where a blanket dispensation, saying anyone who is doing attendant care, needs some kind of definition, because I think, as Randy Hope was saying, if we do it here, then do you start people saying: "Well, look, we're not all that much different either. We should be exempted." I think we can see the need here for a different arrangement, so I am interested in how you would see defining that in a way that would make sense and still provide protection to, say, an individual person who might be misused by an attendant.

Mr Willi: I do not know if it will ever happen, but we would like to see recognition of the concept of self-directed attendant services in the act. This has never occurred before. What may happen in a hospital may rightly be called health services, but you or anyone else cleaning their ears at home are not performing a health service on yourself, for heaven's sake. On one hand, we do not like to quibble over definitions. This is an act to regulate medical professions, and they want to call these things health services? Fine, they should regulate health services. But where we do it and how we do it is a critical difference. When we do it that way, it is not health services. That is our feeling. There is a very fine but extremely important line there.

Think of the attendant as the arms and legs of the individual. That is what an attendant is. This is not a demeaning relationship, either. Attendants are not ordered around by people. This is a very subtle, Zen-like interplay between two individuals who come to know each other and depend on each other and together this really nice thing happens. So it is very difficult to articulate it. It is even more difficult to get people away from the idea that people with disabilities universally need taking care of, protection from themselves. It is very difficult to allow the average person to think of disabled people as having and wanting and critically needing the ability to take risks and fall flat on their face.

Mr Beer: In effect, the protection would be the same as for anybody else in society, and the attendant is just seen as, in effect, an extension of yourself.

Mr Willi: That is exactly right.

Mr Beer: I think we will be really interested in looking at what you come up with, because I think the important thing here is that you are actually saying, "You might word it this way," or "Here is a proposal," because that is where it gets at times more difficult.

The Chair: You have one minute for a comment, but no questions, Mr Wilson.

Mr J. Wilson: It seems to always happen. Thank you very much for joining us. I do appreciate it. I must admit that yesterday we had a disabled person appear before us. I did not quite understand, and I think you have done a good job of articulating what you mean by self-directed attendant care. I now see that the Ministry of Health's exemptions in here where it talks about treating a person can be very offensive.

Just for your information, we have asked towards the end of these hearings to have Community and Social Services people come in, because the remedy you seek may not be in this act. It may not be within the purview of the Ministry of Health. It may be that we have to have a discussion with Community and Social Services about the type of language in their acts dealing with attendant care.

I think you have outlined the difference between the type of treatment in the home that is daily routine treatment and the medical intervention treatment that this act is trying to deal with, but rest assured we are going to keep struggling with it. Towards the end, we will be talking to Community and Social Services and see if we cannot get the language of the different acts so that you could be more comfortable with it.

Having said that, though, I would be very interested, as Mr Beer has pointed out, in seeing what your possible amendment to this section, maybe a 28(e), would be. It may be that its legal bearing is not terribly significant, but its comfort level is.

The Chair: Thank you very much for your presentation. We appreciate it. The video is here. Members of the committee will avail themselves of the opportunity to view it and I know that there will be considerable discussion on this issue over the course of the hearings.

Mr Willi: You will be the first in Ontario to see it.

1540

STUTTERING ASSOCIATION OF TORONTO

The Chair: Mr Jaan Pill, co-ordinator of the Stuttering Association of Toronto. Welcome, Mr Pill. You have 20 minutes for your presentation.

Mr Pill: I want to thank you for the opportunity to speak with you today. My name is Jaan Pill. I will be discussing Bill 43 as it affects speech-language pathologists.

I will begin by saying a few words about myself. I am the co-ordinator of the Stuttering Association of Toronto, which is a support group for people who stutter. I am also one of the organizers of the first-ever Canadian conference of self-help groups for people who stutter, which will be held August 22-25, 1991, in Banff, Alberta. These kinds of groups offer emotional support and help people maintain their fluency after treatment for stuttering. One of the outcomes of the Banff conference will be the creation of a Canada-wide network of self-help groups for people who stutter.

As well, I am a member of the support groups/consumer affairs committee of the International Fluency Association, a new, non-profit, international, interdisciplinary organization dedicated to international contacts among speech pathologists, researchers and support groups involved with fluency disorders.

My remarks will focus on the role of speech-language pathologists within the proposed legislation. I will begin by saying a few words about the area I am most familiar with, and that is stuttering.

I will begin by defining stuttering. Stuttering is a communication disorder in which speech is disrupted by involuntary repetitions, prolongations and blockages of syllables and words. It is usually accompanied by tension and struggle behaviours, such as facial grimacing. The person may feel frustrated and anxious when trying to talk and may attempt to avoid certain words and speaking opportunities.

Research indicates that stuttering is not a psychological or emotional disorder, but is instead associated with anomalies in neuropsychological functioning. There is no cure for stuttering, but treatment methods that are now available enable up to 80% of people who stutter to maintain control over stuttering and thus communicate effectively.

With reference to treatments, extensive research has also been conducted on the effectiveness of treatments for stuttering. Psychotherapy has not been found to be effective as a treatment for stuttering. However, behaviourally oriented treatment methods have enabled many people who stutter to achieve and maintain a marked increase in their level of fluency.

About 125,000 adult Canadians, 0.5% of the adult population, stutter. In Ontario we have an estimated 49,000 people who stutter. Also, up to 5% of very young children stutter during the time they are acquiring language. Up to 80% of these children subsequently acquire fluent speech during the normal course of maturation. The remaining children in this group require specialized assistance from speech pathologists who specialize in stuttering treatment.

Among this group of children, the earlier the condition is accurately diagnosed and treated, the better.

I myself have been the beneficiary of two treatment programs for stuttering, conducted by PhDs in speech-language pathology. I undertook treatment in an intensive three-week program in Toronto in 1976 with Robert Kroll, who has a PhD in speech-language pathology. The program was called the precision fluency shaping program, developed by Dr Ronald Webster, a psychologist in Virginia. Dr Kroll introduced this program to Canada in 1974. Second, in 1987 I attended a program with Dr Einer Boberg at the Institute for Stuttering Treatment and Research in Edmonton.

Canada is recognized as a world leader in stuttering treatment and research. In this context, Einer Boberg, a treatment specialist at the University of Alberta, was recently elected head of a new organization, the International Fluency Association. William Webster, at Brock University in St Catharines and earlier at Carleton University in Ottawa, is a researcher specializing in the neuropsychology of stuttering whose work is widely cited in the international scientific literature on fluency disorders.

To turn to Bill 43, in most ways I find this is a good bill. It will define who does what in delivery of health services in Ontario.

However, the proposed bill does indicate that a person who has a PhD in speech pathology cannot use the title "doctor." That title has been reserved for medical doctors, optometrists, dentists, chiropractors and psychologists. The rationale for this decision is that it will reduce confusion to the public. I submit it will instead add to the confusion and is likely to detract in the long run from effective delivery of treatment to people in Ontario who stutter.

In North America, advances in treatment and research have been made by professionals in a wide range of fields. Some MDs in the United States have made stuttering their specialty. There are also neuropsychologists who have devoted a significant part of their research to the topic of stuttering. One of the standard references in North America concerned with the maintenance of fluency skills after treatment for stuttering is written by two specialists living in Ontario, namely, Marie Poulos, a speech-language pathologist at the Ottawa Rehabilitation Centre, and a psychologist, William Webster, whom I referred to earlier. Also, one of the standard references for Canadian physicians seeking current information about stuttering in children is a recent article by William Webster and Einer Boberg, and I have the references at the end of this material.

I also wish to refer to diagnosis, which in Bill 43 refers to the "communication to a patient or his or her representative of a conclusion as to the cause or identification of a disease or dysfunction."

Physicians are not typically experts in the diagnosis of stuttering. The literature available to physicians is sometimes out of date. For example, there are still references in standard medical tests as recent as 1988 which describe stuttering as primarily a stress disorder. That kind of perception of stuttering in scientific literature was popular around 1950, 1960. Members of self-help groups have

offered anecdotal reports of physicians attempting to treat stuttering by prescribing tranquilizers.

As well, it takes expertise—expertise of the kind available to speech-language pathologists who specialize in the treatment of stuttering—to distinguish between those children who stutter and who will recover spontaneously as they mature, and those children who are not likely to recover without treatment by speech pathologists. If the parents of a child in the latter category are told by a physician that the child will grow out of it, that child loses the opportunity for timely treatment.

Earlier discussions about the bill have noted that a number of participants in previous reviews have submitted that members of other professions with doctorates should be permitted to use the title "doctor" and that it was insulting to suggest they would mislead consumers about their profession or be permitted to do so by their college. Against these submissions, according to earlier documents, "The review has balanced the consumer's right not to be confused or misled, especially when seeking primary health care."

Is there strong evidence that a person with a medical problem, let's say a severe abdominal pain, would walk into the office of a PhD in speech pathology and mistake that person for a medical doctor?

I also note that the restriction on the use of the title "doctor" may also have long-term consequences on salary levels among PhDs in speech-language pathology in Ontario. The quality of service delivery and the quality of research in a rapidly developing field such as stuttering treatment and research are likely to be affected negatively. In economic terms, when you enable a person to gain control over stuttering, you enhance his ability to communicate effectively and you enhance his ability to secure employment that matches his capabilities.

Ontario has the opportunity to continue to play a leading role in stuttering treatment and research. However, Bill 43, as it stands, is apt to discourage young PhDs specializing in speech-language pathology. They are likely to go to more hospitable climates, such as Alberta's Institute for Stuttering Treatment and Research.

In conclusion, as one spokesperson for people in Ontario who stutter, I want to emphasize that the needs of people who stutter would be better served if PhDs in speech pathology in Ontario were able to continue to use the term "doctor" in the same way as psychologists and if they were permitted to diagnose speech disorders that come under their area of expertise.

Mr J. Wilson: Thank you for your presentation. Just on the title "doctor" again, I think the government's intent in bringing forward this legislation, particularly that section which deals with the title protection of "doctor," was not to open a can of worms.

I have a brother, for instance, who has a PhD in zoology and teaches at the med school at the University of Western Ontario. Under the current act, he is allowed to put "PhD" behind his name but he is not to be using "doctor" under the Health Disciplines Act now. It is already restricted to certain—well, this act is expanding it to chiropractors and psychologists.

I do not know what group of politicians started on this slippery slope, but clearly, in my opinion, I agree with you that it is a political decision. We are now going to chiropractors, giving a prestigious title of "doctor." It has been given in the past—I do not know what remedy we can come up with—to essentially people with undergraduate degrees. Society has placed a high regard on the term, when in academia a doctorate of philosophy is the highest degree possible.

I am not sure what we are going to do. If we continue the slippery slope of adding everyone else to the list of people who can use "doctor," I do not think we are serving any useful purpose there, widening the system further. If we stick to what the intent of the bill is now, which is to let people continue to use PhD behind their names, there is no prohibition on the use of "PhD" in this bill.

Mr Pill: There is a very clear indication that, for example, a PhD in psychology can call himself or herself "doctor." I see no rational reason, no reason I can think of in the world, in terms of people who are doing research in the field, why, let's say, a PhD in neuropsychology or a PhD in speech-language pathology cannot call himself or herself a doctor.

Mr J. Wilson: I agree, so I guess my question is, given that under the current legislation in Ontario three different groups—optometrists, MDs and dental surgeons—have the ability, and given that I think we are going to have a difficult time as a committee deciding where we should be granting the ability in the future and where that list should stop, do you perhaps think maybe we should not do what this act proposes, which is just to extend it to chiropractors and psychologists, but stop whatever has been done in the past and not proceed with it, take it out of this bill, for instance, and just let things stand as they are? If you are using "doctor" in practice, that is fine. The only onus now is if the medical profession decided to sue you—and the fact is that I do not think there have been any law cases. My brother is not going to get sued because at the university he is known as Dr Wilson, even though technically under the Health Disciplines Act—I could be wrong—he is not really supposed to be using that. He is supposed to be John Wilson, PhD.

Mr Pill: I could also refer to something in the background documentation. There is a reference to the fact that: "Any person may use the title in a hospital laboratory or other regulated institution. Restrictions apply only to persons using the title as an occupational designation relating to the provision of human health care." That particular statement is not in the final bill, as far as I know. There is no clarification on that point. In terms of logic and consistency and in terms of practice in other jurisdictions, I think it might be an idea to look more closely at that.

The Chair: Thank you very much for your presentation. We appreciate it.

1550

H. AYALA MANOLSON

The Chair: We have Mrs Manolson. Welcome. I said yesterday that the committee gets very friendly at

about 5 to 4, so please relax. You have 10 minutes for your presentation.

Mrs Manolson: I am executive director of the Hanen Centre. It is an organization that is committed to ensuring that children get the opportunity to be able to communicate to the best of their ability. Our purpose is to support families and teachers to make that happen. As a centre, we employ many speech-language pathologists and are very pleased that the government is proposing to regulate our profession. This regulation will benefit the public by ensuring that the profession develops and maintains a standard of practice that is in the public interest. But as you are aware, I am here because we feel there is a problem.

In Bill 43 there is, in section 26, a controlling act that is omitted in our legislation. I will cite that. It reads "communicating to the individual or his or her...representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her...representative will rely on the conclusion."

This is a lot of legalese. To talk about diagnosis, to be able to look at a child who is not developing language properly, to assess what the problem is and then to have the ability to share that information so that the person can act upon it—in the legislation, as it is now written, we as speech-language pathologists do not have that authority. This controlling act does not appear in Bill 44 and limits the scope of our practice. We believe this omission is not in the public interest and that this restriction will impair the availability and accessibility of our centre's service and the services of other centres like ours.

We achieve the goal of ensuring that every child learn to communicate to the best of his ability by providing parents with the knowledge and support to be able to effectively intervene to allow that child to reach his potential. In practical terms, it means that the parents can refer themselves to our centre. We as speech-language pathologists assess them, and if our assessment results indicate that we can help that family, then that conclusion is communicated to the family. It is essential that each family know as much as possible about their child's language development so they can make an informed decision on what they can do to improve it.

To suggest, as the legislation does, that speech-language pathologists are limited to doing assessments and can no longer identify the problem and discuss possible solutions with the family would indeed mean a lessening of the quality of services these families are currently receiving. If the legislation is followed to the letter, a speech-language pathologist at the Hanen Centre would do an assessment and then inform the family that they must visit their doctor, or someone else who has this authority, to discuss their conclusions.

We feel that this affects our service in many ways. We feel that the quality of the service would be reduced in that the doctor having to discuss the speech-language pathologist's conclusion would interfere with our ability to be direct with the families, to gain their trust, to establish a rapport in which they can begin to assume some responsibilities for decision-making and action.

We question whether the consumer will be well serviced by this system. As an administrator, I am aware that this will involve increased demands upon us. We have to set up a system whereby after the assessment we book appointments with doctors and the doctor's assessment is referred back. In addition, there is an increased cost, because this will cost my time, my staff's time, the doctor's time, and we really wonder whether this money is well spent. I mentioned just briefly, but I think, for my purposes, the most significant thing is the lessening of the credibility and rapport we are able to establish with our families and in that way it really lessens our credibility.

We fund several projects, but one particularly that this affects is one at Jane and Finch where we have been able to provide speech-language pathology services in high-rises where single moms on welfare live. These mothers are not able to access the system. To gain their trust is our first major accomplishment, and we have been able to do that. I know that if we said to them, "Look, we'll have a look at the situation here, but then we're going to refer you to a doctor; the doctor will tell you and, if he thinks it is okay, then you can come," we would lose all those mothers. It has been a very interesting and very enlightening experience to recognize just under how much stress some families must live and how much support they really should have in order to ensure that their children have the opportunities to grow and develop and have opportunities that these mothers have not had. These mothers are anxious and willing to participate in something that will help their children, and I feel that this would really impede it.

The irony of this restriction is that it entrenches what a lot of our families feel is wrong with the system, and that is that parents have often expressed a disappointment when they have gone to doctors and said, "Look, my child is not communicating well." Our field is a relatively new field. For us to keep current is a real commitment. For doctors, who have so many other responsibilities in also developing areas of their expertise, to have the knowledge to be able to identify children at risk of language delay, or even those who are language-delayed, is problematic. So many parents come to us and say, "You know, I went to my doctor, but he said not to worry; Einstein didn't talk till he was five, but my child is five and he's still not talking, and I'm very upset because he's going to school and he's not going to be able to cope," and a lot of time has gone by. So I guess my concern is that the omission of that controlling act is going to perpetuate a problem that already does exist.

In conclusion, I would like to point out that the model we have developed at the Hanen Centre does not only service Metro Toronto; we have registered with us over 100 speech-language pathologists throughout Ontario who also follow this model. Whatever restrictions and loss of effectiveness we will suffer, that would be perpetuated and increased and multiplied throughout Ontario.

I would like, in conclusion, to ask the committee that recommend an inclusion in Bill 44 of that controlling act that would allow speech-language pathologists to communicate their diagnosis on the disorders and dysfunctions related to their scope of practice.

Mr J. Wilson: In your own words, why have you not been given the ability to communicate the results of your assessments? In your own words, why do you understand you have not been given that? I think I am going to ask every witness this.

Mrs Manolson: I have tried to find out. It is a very political question, in my mind, because the limited exposure I have—and I have asked—is that possibly it is an oversight. Possibly there is a feeling that, "Well, it isn't there, but it doesn't really matter because we all know it's going to be okay anyway." Possibly it is because somewhere way, way back somebody in the medical profession felt that, "Really, this is a domain that we really should monitor, and this is the system and rules by which we would like it to be played." I am not sure which of those—and it could be something else. I would like to know the answer.

Mr J. Wilson: Thank you. We are grappling with it.

The Chair: Thank you very much for your presentation. Our committee appreciates hearing from you.

Members of the committee, we have had our last presentation for the day.

It was decided that there would be a meeting of the subcommittee following immediately for just a few minutes. This is the end of the first week of public hearings. I would be interested in hearing from anyone, through the subcommittee or otherwise, any comments or suggestions about future hearings.

The other thing is, would you take everything with you tonight? It will not be possible to guarantee that if you leave them in this room everything will be here by Monday because the room is being changed over the weekend, so we would ask that you take everything that you are going to want home with you. If you leave it here, it will probably disappear and you may never get it back.

The committee is officially adjourned until Monday at 10 am.

The committee adjourned at 1602.

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of Ontario**

First Session, 35th Parliament

**Official Report
of Debates
(Hansard)**

Monday 12 August 1991

**Standing committee on
social development**

**Regulated Health
Professions Act, 1991
and companion legislation**

**Assemblée législative
de l'Ontario**

Première session, 35^e législature

**Journal
des débats
(Hansard)**

Le lundi 12 août 1991

**Comité permanent des
affaires sociales**

**Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent**



Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
Greffier : Lynn Mellor



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 12 August 1991

The committee met at 1003 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi de 1991 sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: I would like to welcome everyone to the standing committee on social development. There is a member here from each of the three caucuses. I would also like to welcome the parliamentary assistant, Mr Wessinger. There are a couple of items which will be considered housekeeping, just for the information of the caucuses and particularly for the whip.

We have pretty much filled all of the available time slots for the committee hearings. We have some people waiting, some waiting lists, and I have discussed this with the clerk. As you know, last week there were some cancellations that came in on the day of the hearing and it was very difficult to contact someone and have him come in time. She will endeavour to slot in those that are waiting in any time slots that are vacated. If you know of anyone who has a time slot and is planning not to appear before the committee, it would be helpful if he gave the clerk as much notice as possible so that his time slot can be used by someone else. All those who are on the waiting list will be notified that they can submit letters or briefs or comments in writing to the committee.

I wanted to make that information available to all members of the committee just to let you know what the status is at this time.

ASSOCIATION OF HEARING INSTRUMENT PRACTITIONERS OF ONTARIO

The Chair: I see that our first group is here, the Association of Hearing Instrument Practitioners of Ontario. I want to welcome you. Please introduce yourselves. You have 20 minutes for your presentation, and we would ask that you leave some time for questions from members of the committee at the end of your presentation.

Mrs Bernath: My name is Dianne Bernath. Beside me are Joanne Sproule and Christine Helik.

The Association of Hearing Instrument Practitioners of Ontario respectfully requests the removal of prescription of hearing aids as a controlled act for audiology, Bill 44, and medicine, Bill 55. Our reasons for this request are as follows:

First, in 1987, when Alan Schwartz presented his preliminary report, there was no mention of prescription of hearing

aids as a licensed act for either audiology or for medicine. After five years of careful deliberation, numerous interviews, presentations and briefs, Mr Schwartz determined that there was not significant or sufficient risk of harm in the process of acquiring a hearing aid to warrant its inclusion as a controlled act in the proposed legislation. Six months later, that decision was reversed. Why? That is a very good question. Repeated requests of ministry personnel for documented evidence to justify this change have remained unanswered.

Second, consumers and other health care providers, particularly those in nursing home administration, have clearly expressed the Ontario Advisory Council on Senior Citizen in numerous letters to ministry personnel, members of Parliament, and the advisory committee on hearing aid services, that they do not want their choices limited in accessing hearing aid services. I have with me, as exhibit 1, thousands of names of consumers and their families who are asking you not to make prescription of hearing aids a controlled act.

Third, in December 1988, in anticipation of the proposed legislation, the Ministry of Health introduced policy which reflects its interpretation of the proposed legislation. That policy allows only audiologists to become registered to provide assessment services for the purpose of selecting a hearing aid. As a result, the number of hearing instrument practitioners who have historically provided these services is deteriorating rapidly, and with that, the service locations, particularly in the rural areas of this province.

In December 1988, under the direction of the Ministry of Health, the Association of Hearing Instrument Practitioners of Ontario conducted a survey. We contacted every known hearing aid dispenser in Ontario and we asked them several questions, one of which was: "Where are you located? Where do you have suboffices? Where do you have regular scheduled clinics on a monthly basis?" We took this information and we plotted it on this map in these purple dots. As you can see, the province was very well covered at that time. Many of the very tiny rural communities that would otherwise not have services were being well provided for.

In 1990, we conducted a similar survey. We went back and we asked the same questions again, but this time we said: "What has changed? We want to know what you are doing now differently from 1988." This is the result of what we found. Each one of these little orange dots represents the removal of a clinic in the Ontario in two years. As you can see, there are certain areas that have completely had service removed and nothing has been brought back in to replace it.

1010

So that you get a better perspective on the whole picture, we have also plotted the locations of the audiology clinics in Ontario. These are numbers of clinics, in all cases; they do not represent the number of people. As you can see, in

certain areas—for example, Haliburton, Victoria county—there are no audiologists. In Kitchener, where there were six last year, the audiology clinic at the hospital has closed until September because its last clinical audiologist is ill, so you can see that the services in the area are decimating fairly quickly and there are not a lot of replacements.

There is a total of 259 audiologists in the province. In 1988, there were 242 audiologists. That number decreased in 1989-90 to 234. It has now increased to 259. That is a main increase of 7% over two years—certainly not enough to offset the decrease of more than 30% in our numbers in the same period of time.

It is also interesting to note that in fiscal year 1990-91, there was a decrease of almost 10% of the hearing aids dispensed in Ontario, in a time when the numbers of senior citizens are growing rapidly.

We have proven over a 14-year period that hearing instrument practitioners can be and have been educated at the community college level to provide quality, community-based care to the consumer in a cost-effective manner. Nowhere in North America is it deemed necessary or even desirable to involve audiologists in routine assessments for the purpose of selecting hearing aids. We submit, therefore, that prescription of hearing aids as a controlled act will result in the exact opposite of what this legislation was intended to do. It will remove safe choices for the consumer. It will limit consumer options, eliminate community-based care, remove home care for the elderly and disabled, while substantially elevating the cost to our already overburdened health care system, with no evidence that there will be an improvement in the quality of care to the consumer, only restrictions.

I ask you to consider what is to become of the hundreds of thousands of hard-of-hearing seniors who have historically depended on hearing instrument practitioners in their communities, homes and nursing homes to assess their hearing, and select, dispense and maintain their hearing aids. Many of these seniors are non-ambulatory or find it difficult, if not confusing, to be transported to hospital clinics where they receive impersonalized, fragmented services. Is this really the intention of this legislation? What of someone in the workforce, or a university student, who cannot function without her hearing aid and it needs to be replaced? Why should they have to wait for months to go through a hospital clinic for a prescription when there is a safe, efficient alternative?

We further submit that the inclusion of prescription of hearing aids as a controlled act in this legislation is a bureaucratic decision that cannot be justified or withstand close scrutiny. This decision was not based on significant risk of harm—it was just rhetoric information—nor has it been introduced to address consumer concerns, complaints or consumer preferences. Prescription of hearing aids does not belong in this legislation. We ask that you amend the legislation accordingly.

May I answer any questions.

Mr J. Wilson: Have you seen any documented evidence, from the ministry or otherwise, indicating that there is a risk of harm in prescribing hearing aids?

Mrs Bernath: Absolutely none.

Mr J. Wilson: Your reasoning just a minute ago was that perhaps it is a bureaucratic insertion. Do you want to expand on that at all?

Mrs Bernath: What we are looking at is provincialism, in our opinion: that is, self-serving for one group. If you take a look historically at how hearing aids are fitted and worn, there are methods in the way a hearing aid is assessed. The needs of the person are assessed. Routine assessments will protect the consumer from any harm as far as the hearing aid being too strong or not being appropriate is concerned, and also the consumer will not wear a hearing aid that is not appropriate, so we are not sure where this risk of harm is coming from. We do not see any indication of it.

Mr Owens: I would like to ask the minister's staff, through the parliamentary assistant, how did the ministry come to the conclusion that the prescription of a hearing aid should become a controlled act if in fact, as the deputants have alleged, no consultation was made with their association or any of the providers?

Mr Wessinger: I will ask ministry staff to reply to that.

Ms Bohnen: The recommendation that prescribing a personal hearing aid should be a licensed or a controlled act was made by the Health Professions Legislation Review. So it was not a shift in policy made by the ministry after the Schwartz recommendations were delivered. The review determined during its consultation with provider groups, such as physicians and audiologists who you will be hearing from later this morning, that there was a sufficient risk of harm to the consumer caused by the risks to that individual of an improperly prescribed hearing aid to justify making it a controlled act, performable by both audiologists and physicians, as you have heard.

I might also point out that the controlled act itself does not prevent hearing aid dispensers from testing individuals' hearing and making recommendations about a particular type of hearing aid that would be necessary, but we are talking about a generic prescription of a hearing aid.

Mr Grandmaitre: Could you briefly describe your training? How would you become a practitioner in Ontario?

Mrs Bernath: At the present time, there is no training. As of January 1989, the last graduates of Sheridan College came through. In 1974, there was a full program designed. It went over a period of 14 years. There are well over 100 practitioners in the province currently who have graduated from that program. It is a program that has been designed specifically not to produce audiologists, but to produce hearing instrument practitioners who specialize in selecting and testing and dispensing hearing aids, and we are asking for that to be reintroduced.

Mr Grandmaitre: This program you are referring to, is it a two-year or three-year program, or a six-month program?

Mrs Bernath: It was a one-year program with 50 hours of clinical practicum on the side besides that, one year plus.

Mr Grandmaitre: One year plus.

Mrs Bernath: Plus 50 hours of clinical practice, yes, supervised practice.

Mr Grandmaitre: As far as training is concerned, when you compare the two practitioners, hearing instrument and

audiologist, there is quite a difference in the training. Do you think the audiologists are better trained than you are and more capable of determining the right instrument?

Mrs Bernath: I would suggest to you that if you examine the program profile and then part of your package that we have given you, it will show you the number of hours spent on each area criteria in this brief that we have presented to you. You will see that the training audiology receives is much more involved, but is not designed with the intention of doing routine assessments for selecting hearing aids. It is not necessary to have an audiologist involved and it is a very expensive waste of good manpower, in our opinion. There is a better use for audiology, and that is to use them in the upper-echelon testing, the multihandicapped, the aural rehabilitation and the research for which they were trained.

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Mr Jackson: Just on the parliamentary assistant's and staffs' response to the concept of risk for inappropriate hearing aid dispensing, were there specific cases documented by the ministry? Was there a proper complaint system, and if so, how many cases were reported? I do not want to challenge your concept; I just want to say, how does the government measure that?

Mr Wessenger: I will ask staff to comment on the specifics.

Ms Bohnen: Since the recommendation, as I said, was made by the Health Professions Legislation Review, the Ministry of Health itself did not conduct an analysis of complaints received by any particular branch of the ministry prior to that recommendation having been made by the review. The issues that were examined by the review had to do with the harm to the patient of incorrect amplification, of missing a diagnosis, the symptom of which is hearing loss, the pain to the patient caused by noises generated by an improperly prescribed hearing aid.

Since over the past few years the assistive devices program of the Ministry of Health has assumed responsibility for administration of the program and it pays for many hearing aids, it is possible that it may have some information, but its program is not really geared to focusing on this issue. So I do not know that there is available information, to answer your question.

Mrs Bernath: Madam Chair, could I just finish with one brief word?

The Chair: Yes, please.

Mrs Bernath: I am going to state once again that this legislation based on significant risk of harm. There has been no documented evidence. This is total hearsay. We are losing affordable services in Ontario and wasting considerable dollars in doing so.

The Chair: Thank you for your presentation. I would point out to all committee members that Mr Schwartz will be appearing before the committee on September 15. I would also suggest to the caucuses that if through the course of the hearings they determine in advance specific questions that they want Mr Schwartz to address, they should give

them to the clerk, who can pass them on to him in advance so he will be sure to address them in his presentation.

CANADIAN ASSOCIATION OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

The Chair: The next presenter is the Canadian Association of Speech-Language Pathologists and Audiologists. Please introduce yourself. You have 20 minutes for your presentation.

Mr King: My name is Richard King and I am the executive director of the Canadian Association of Speech-Language Pathologists and Audiologists. I have only 20 minutes, so from now on it will be referred to as CASLPA. We are over 2,700 professionals throughout the country representing speech-language pathologists and audiologists in all of the provinces and territories. This includes the 16 professionals who comprise all of the speech-language pathologists and audiologists in the province of Prince Edward Island, as well as almost 1,000 members here in Ontario. CASLPA estimates that we currently have as members 75% of all of the professionals in Canada. We are also over 500 student members studying at the graduate level.

The mission of our association is to provide national leadership in human communication and its disorders. This includes the development of public and professional policies affecting individuals with communication disorders and the advancement of the professions of speech-language pathology and audiology in Canada. It is with this mission in mind that we come to speak this morning.

I am here to speak to specific issues that we feel are important for the best service to those with communication disorders as they are to be addressed by this legislation. As an association dedicated to promoting the needs of those with speech-language and hearing disorders, as well as developing and promoting national standards for practice, we feel that we present a significant point of view.

At the outset we would stress that CASLPA supports this legislation, Bill 43 and Bill 44 specifically. The intent of the legislation, to provide the best health care for the people of Ontario in the most efficient way, is certainly what all of us want. We believe that the changes to the four areas to be presented here are but refinements to these bills, refinements that will enhance the level of health care and its efficiency. We feel these recommendations in no way run counter to either the intent of this legislation or to the common good of the people of Ontario.

There are four areas in relation to Bill 43 and Bill 44 that we would like to address at this time. Because of the time allowed, I will attempt to address only the most salient of the four issues.

The section in Bill 43 on conveyance of a diagnosis: The act as it is now written would restrict speech-language pathologists and audiologists from conveying a diagnosis to their clients. The act would limit this function solely to physicians and psychologists. Such a communication of a diagnosis would be a terribly inefficient use of a health care system and would place an important aspect of health care in the hands of the wrong people.

This is not to suggest that physicians and others do not deal with such diagnoses, but it is to suggest that when a

speech-language pathologist or an audiologist arrives at a decision regarding a diagnosis, these professionals should be the ones to convey that diagnosis to the client and his or her family. The speech-language pathologist or audiologist best understands how the diagnosis has been arrived at, what it means, and is indeed the person best able to counsel about such a diagnosis. The speech-language pathologist or audiologist can also explain the long-term significance of that diagnosis and the therapeutic steps that may be taken in light of it.

To suggest that any other person would be involved in conveying a diagnosis arrived at by another professional overlays such an inefficient structure to the health care system that one can barely consider any benefit to such a move. To assume that a secondary party could bring to bear on the diagnosis all of the information and background that would be necessary is not reasonable.

Diagnosis is really inseparable from other activities of speech-language pathologists and audiologists. Diagnosis is often an ongoing part of an assessment and treatment plan and therefore must be dealt with accordingly. As patients progress, further information regarding diagnosis must be passed on. Again, to suggest that this would be done by a secondary party is not reasonable. Patients certainly have the right to discuss their assessments and the resulting diagnosis with the professional best trained and most knowledgeable in that area. The current legislation does not appear to consider this.

Diagnosis is a very significant part of our training and is included in our scopes of practice which serve as the basis of CASLPA's certification exam. Our association certifies professionals throughout Canada. This certification is based on membership in our organization as well as passing our certification exam.

We distribute a document titled *Assessing and Certifying Clinical Competency, Scopes of Practice for Audiology and Speech-Language Pathology* to all applicants for our exam. These scopes serve as the basis for the exam. The document was first published in 1988 and republished in 1991. I am sorry I do not have copies for all the members of the committee, as we are just about to write our exam and we have to pass them out. I do have copies for the Chair, one in each official language. The scopes in fact are a report of both our association and the institutional and professional services division, Department of National Health and Welfare. The document is published by the health services and promotion branch, Health and Welfare Canada.

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In both the scopes of speech-language pathology and audiology, diagnosis is presented as a critical area of knowledge. Professionals in these areas are specifically trained to diagnose communication disorders, and the importance of diagnosis is stressed in the document. With this in mind, it is difficult to comprehend that speech-language pathologists and audiologists would not be the most appropriate people to convey such a diagnosis. This is a significant aspect of health care. It must be done efficiently, and it must be done appropriately.

Bill 44, the section on title restriction: Historically speech-language pathologists have suffered the confusion

of the public because of our titles. Certainly the title "speech therapist" is a long standing designation for the profession of speech-language pathology. Therefore, this title should be protected as it continues to be recognized and sometimes used interchangeably with "speech-language pathologist." Though the latter is currently considered in North America the more accurate term for the profession, and has been adopted as appropriate by graduate schools throughout North America, we cannot deny that other titles continue to be used by the public, and therefore these other titles should be protected. This is in the best interests of the public.

The title "speech therapist" is important because of its long-standing use, and because many in our field have this title on their degrees. For example, there are many clinicians in Ontario, educated in the United Kingdom, whose degrees are those of licentiates in speech therapy. Legislation such as this should certainly be directed at protecting the public. Unregulated persons should not be allowed to use any designation that could be confusing, especially "speech therapist." To place this title outside this legislation will create a void regarding its use that will invite misuse by others, and further confuse the public.

We would suggest that the New Brunswick Act Incorporating the New Brunswick Association of Speech-Language Pathologists and Audiologists is an example of protection of title that is of benefit to the public. I enclose for you the chapter and section in appendix A at the back of my brief. This document outlines a complete list of titles to be used only by those appropriately qualified, including speech therapists and other derivatives.

I realize that what is written here may not be the particular way we want it, but it is an example of protection of title, which is of benefit.

Bill 43, the section on the use of the term "doctor" This section of Bill 43 would restrict the use of the title "doctor" to members of the colleges of chiropractors, optometrists, physicians and surgeons, psychologists and dental surgeons. This would exclude health care professionals who also have earned the title "doctor" and hold PhDs in other areas such as speech-language pathology, audiology, nursing, pharmacy—and there could be others.

This part of the legislation would seem to run counter to the spirit and intent of the Regulated Health Professions Act. We contend it is the patients' right to know the degree status of any and all who may serve them. Not to allow the term "doctor" to be used would appear to be an active attempt to deny information to patients.

To pick out certain professions and to allow them to use the term "doctor," whether they have a PhD or MD appears arbitrary. Nationally and internationally, a PhD is "doctor." To attempt to alter that with this legislation would seem to run counter to conventional standards of such recognition. Certainly to allow PhDs in one field to use the title "doctor" while restricting it in another seems most unjustified and unfair.

There are other concerns in our professions regarding the use of the term "doctor." Over the last two years, our association has had discussions with Employment and Immigration Canada regarding some of the difficulties our professions have had in providing a sizeable enough work

force for the population of Canada. One of the areas that has been identified as a difficulty is the small base of PhDs existing in Canada. It is obvious that if our professions are to adequately serve Canadians, we must expand the basis of those trained at the PhD level who serve as teachers and researchers.

CASLPA, with Employment and Immigration Canada, has begun to look at how we may not only train more PhDs in our fields, but also attract and maintain them. Such a move as is suggested by this legislation would certainly be detrimental to the professions and to the public.

Ontario currently has two very fine programs at the University of Western Ontario and the University of Toronto. These programs train speech-language pathologists and audiologists at the graduate level. As these universities compete with universities throughout the world for professors and researchers, one can only surmise that legislation such as this would be detrimental to both attracting and maintaining PhDs in this province. One may argue this to be a matter of symbolism, but we would suggest that does not diminish its importance at all.

Bill 43, the section on the prescription of a personal hearing aid: CASLPA contends that the prescription of a hearing aid is most adequately and efficiently addressed by audiologists. Audiologists are the professionals specifically trained in this area of health care. Inappropriate assessment, or the application of an inappropriate aid, can cause physical and mental harm to patients. The master's degree is the recognized level of qualification for audiologists, and is the necessary level of qualification to adequately prescribe a hearing aid.

I again refer you to our publication, *Scopes of Practice*, which covers this area. CASLPA certainly recognizes that there are difficulties in the provision of this area of health care throughout Canada, but we strongly suggest that to lower any standard in relation to those who may prescribe a hearing aid would be tantamount to lowering this standard of health care.

In the limited time available here, we have attempted to stress four areas of this legislation that we feel may be refined and improved. We recommend some further attention to these areas with the intent of better delivery of quality health care as well as protection of the public. We feel that if these recommendations were to be acted upon, this legislation would be enhanced.

The Canadian Association of Speech-Language Pathologists and Audiologists appreciates this opportunity to present to you today. We are pleased to be here on behalf of our members, and in support of the Ontario Association of Speech-Language Pathologists and Audiologists. We know that other groups and individuals are competing for your attention on these matters. Differing points of view will be heard. The voices of professional associations, consumer groups and individuals should be heard. Our association, as a national voice, has been pleased to be part of this process here in Ontario. I would be pleased to answer questions.

Mr Sola: I am interested in your latest comments about the provision of inadequate hearing aids. I am wondering how often this occurs, and which of the professions,

or the professionals that prescribe hearing aids is most often the culprit?

Mr King: I do not have specific information on that. The contention of our association at this time is more that the specific training at the highest level for the best health care is received by audiologists at the graduate level. It is that background and knowledge that they bring to this area of health care which is most important. I am not aware of a study that has compared the problems resulting from this between the two groups.

Mr Sola: As the parent of a child who uses hearing aids, and another child that has a hearing problem in one ear, I am interested in getting the best service available for my children. At the same time, Ontario is a huge province, and as the presentation before you made clear, there are huge areas in the province that have little or no service of any kind. I would be interested in finding out if there is any study to confirm what you have said about the inadequacy of hearing aids, because I would like to pinpoint who is responsible for that.

If I lived in the north, or one of the areas that has no service right now, any service would be better than no service, because quite often these people cannot afford to come to southern Ontario to get treatment. I am not interested in turf protection, if that is what is going on here. I am interested in getting the best service for the money, and adequate service for everybody in the province, rather than excellent service in selected areas in the province and no service whatsoever in other areas.

Mr King: One comment I would like to make is that some service versus no service, if the service provided is not appropriate, is not good service.

Mr Sola: That is why we need a study to pinpoint where the fault lies.

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Mr J. Wilson: Continuing along the same line of questioning, the non-audiologists, the Association of Hearing Instrument Practitioners of Ontario, claimed that it is not necessary to have a master's degree to prescribe a hearing aid. Would you agree with that? Clearly you do not, but just to turn around the question from Mr Sola, is it really necessary, in your opinion, to have a master's degree? We will give you a chance to explain it on the record.

Mr King: Yes, I think it is necessary. It is an aspect of training at our level that is specifically designed for a high level of quality care. As I stated at the conclusion of that section, I think that to lower that is to lower the standard of health care. I know the Ontario association can present some information to you that the province is covered by services that are better than, I think, what was previously detailed.

Mr J. Wilson: That is the contention, and yet no one has been able to bring forward any evidence that there is a serious risk of harm in the work that is being done by non-audiologists. As legislators, we cannot just go on contentions and hearsay. We have to go on fact.

Mr King: I am not certain that the way the question is posed, professionals versus the others, is exactly the best

way to pose it. It will have to be looked at, I agree, but the suggestion that anything less than the best service and the most adequately trained people, and that you are going to allow that service to exist, is not, I think, in the best interest of the people of Ontario. The contention is that there is a risk of harm, and the risk of harm does exist. We do know that there is a risk of harm in the prescription of the wrong hearing aid.

Mr J. Wilson: How many people are you graduating into audiology every year, and is it sufficient to cover the province?

Mr King: It is not nearly enough, but it can be demonstrated that with the growth that is predicted, there will be much greater coverage in the province by audiologists than in the past. There are shortages of speech-language pathologists and audiologists throughout Canada, but again we would suggest that another provider is not the answer. We would love to see more programs. There are only seven programs in communication disorders in all of Canada. I do not think the provision of others in the face of that is the answer.

The Chair: Thank you very much for your presentation.

ONTARIO ASSOCIATION OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

The Chair: The next presenters are from the Ontario Association of Speech-Language Pathologists and Audiologists. Would you introduce yourselves, and we would ask that in the 20-minute presentation you leave some time at the end for questions.

Mr Murphy: We would like to thank each of you for the opportunity of speaking today. My name is Randy Murphy and I am a speech-language pathologist. My colleague is Barbara Kurpita and she is an audiologist. Today we were asked to speak on behalf of the Ontario Association of Speech-Language Pathologists and Audiologists to present the views and concerns of speech pathologists and audiologists around the province with respect to the impact of this legislation on speech-, hearing- and swallowing-impaired patients throughout Ontario.

We are here today to talk specifically about two areas. The first relates to support for the legislation in a generic way. Second, we will raise some of our concerns about the legislation as it is currently written, and this will be done under three main headings: diagnosis, title restriction, and prescription of a personal hearing aid.

The Chair: Could I ask you to speak up a little bit? Some of the committee members are having some difficulty.

Mr Murphy: Certainly.

Mr Grandmaitre: They need a test.

Ms Kurpita: That is my job.

The Chair: The interjection is noted. Please continue.

Mr Murphy: I would like to mention that our association overwhelmingly supports the intent of this legislation in that it serves to provide a broader degree of accountability than currently exists and will provide a unifying system for consumer protection. It will also help to ensure that the high quality of care that currently exists in the province will be

maintained, and will also result in a fairly cost-effective service across health care.

However, there are several areas of concern we feel we would like to discuss today. The main concern for speech therapists and audiologists around the province is what impact some of the principles contained in the legislation will have on our patients.

I should start with the topic of diagnosis. As speech language pathologists and audiologists, primarily we would collect information on patients, maybe do testing on them, and speak with other health care professionals around things that go on with either a speech, hearing or swallowing problem. We would talk with you and your family to find out just how that is affecting broad aspects of your life. We would analyse the information and then develop a conclusion which will give us an idea of where these things are going wrong for you. From that we would discuss with you and your family what kinds of treatment plans we could develop for you and with you, and how that might improve your ability to take life on.

The process I have just described to you is perhaps best described as diagnosis. That is the way, essentially, diagnosis may be defined in the legislation itself. Ministry officials have often indicated we really do not have to worry about the way diagnosis is written, but quite frankly I do worry. Our lawyer, and certainly the lawyers for a variety of other health care groups, have indicated that one very possible interpretation of the legislation is that I cannot do what I just described. I could assess you, I could develop a treatment plan and come to conclusions about what is going on with you with respect to a speech, hearing or swallowing problem, but I could not communicate that to you. For that to happen, you would need to see someone who has an authorized act to do that, which would include physicians, psychologists and a few other groups.

We feel this will create a number of problems, at least according to my legal opinion. First, it will create an increase in the length of time you will wait. I know the length was discussed earlier. Certainly, if I cannot get on with my job and I have to send you on to somebody else who will tell you what I just did, it may be a while before you make the appointment and eventually end up back on my doorstep again.

Second, there is a real potential to have a negative effect on the relationship we develop. You come and see me and all of a sudden we do this nice job, we spend an hour or two together discussing what is going on, and all that is left is to tell you: "You have to go on and talk to somebody else now. I cannot really let you know what is going on." You are going to begin to wonder whether I really know what I am talking about and whether I can really do the job. In the end, I guess one might even suppose that all this travelling back and forth has the potential of increasing costs to OHIP.

We urge you to change this situation now. It is our belief that this issue could go to the courts. It may take a number of years to decide. It is an issue that leaves many of the health care professions, including ours, confused and we feel that same confusion will be brought upon the

public as well. We feel it can be fixed now, that perhaps the committee could provide an amendment to do just that.

Ms Kurpita: I would like to add a few points about diagnosis from an audiologist's point of view. As an audiologist, I first talk with the patient to find out what he thinks the problem is. Then I do a variety of tests to find out where his hearing loss is. I talk with that patient and his family members or other people he has brought with him to interpret my test results for them and to discuss appropriate recommendations. We have a dialogue during his time. They ask questions as I am discussing the test results. It is important that people who come to see me have enough time in my office to ask questions and that they feel comfortable, that they do not feel intimidated. In my setting, people often feel very comfortable and I am proud of the fact that they often leave my office saying: "Thank you, you have been very helpful. You have answered my questions."

If diagnosis, as it is currently written, means I cannot do what I have been doing, that I cannot talk with my patients and discuss the test results, then we strongly feel it needs to be changed.

Our recommendations are on page 7 of the brief.

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Mr Murphy: The next area I would like to raise for our discussion relates to title restriction.

The legislation provides protection for the public in a couple of ways. Primarily it is through the provision of a number of authorized acts. That was bandied about earlier, that if there is the risk of harm those particular acts are governed by the legislation and are given to specific groups.

Second, it is provided through title protection. Members of professions have specific titles protected and anyone else who is not a member of the profession may not use those titles. To allow people the benefit of that aspect of the intent of the legislation, we urge you to protect the title "speech therapist." Typically, in my job as a speech pathologist or speech therapist, when I meet patients I describe myself as a speech-language pathologist. More often than not shoulders go up, eyebrows go up and they wonder whether I take bodies apart.

Essentially, when I say the words "speech therapist," a lot more calmness comes over people because it is a lot less threatening, but they do seem to understand what I do there. They have had some experience with that. In fact, when government agencies look for one of us to work for all of you, you advertise the title "speech therapist." There are some examples in the brief, in the appendices that indicate how that is done.

To eliminate the confusion on the part of consumers, the government as a consumer and other government agencies as consumers of our services, we ask that an amendment be placed forward to protect or include the title "speech therapist" along with "speech-language pathologist." We feel this will have no impact on access to service.

Essentially we do our assessments, come up with a treatment plan in terms of what might help you or your loved one best to overcome some type of communication

problem, and then we would enlist your help, sometimes a volunteer's help, to actually carry all this work out.

I believe part of what gets done in therapy can be done by others, and we encourage that this be done. That is a more cost-effective way of accomplishing our goal.

We are not looking to prevent somebody who might be doing some effective therapy from doing so in the future. The idea of the legislation or its intent is to protect title. "Speech therapist" is a title to protect. We are not protecting the act of speech therapy, just that the consumer has the right to choose who is regulated by law and who is commonly known as that. Again, we would ask that this be done now before the legislation is passed.

The next issue I would like to discuss relates to use of the phrase "in health care." The recommendations initially provided by Schwartz were changed somewhat when this legislation was finally introduced. What ended up being changed was a phrase that said all groups that restrict title would be restricted, but in the course of providing health care. Perhaps on the surface that seems to make a little sense, but I think we need to look beyond that.

There are a number of areas where service providers like myself may not work for a typical health care agency; school boards, for example. Industrial audiologists is another example. There are areas where people could easily say they work beyond the confines of health care. The legislation clearly will not protect people in situations like that because of that narrow definition. The phrase "in health care" really limits public protection for a number of reasons, and I will tell you what we feel they are.

"Health care" itself is an ill-defined term. It is one I am sure will be discussed over the next little while, but one that apparently over the last few years has been very difficult to define adequately. Second, a number of professionals work in non-health settings, not only ourselves but some of the other allied health professions from whom you will be hearing and may already have heard.

Certainly anyone could use one of the restricted titles, which is the basis for providing protection to the consumer, as wanting to do it in a setting which you can describe as non-health. In that situation, the consumer has no avenue for protection and yet this legislation's initial intent was to provide consumer protection, not in a narrow area but across your life, all of your experience across the province. This inadequacy could be rectified by the provision of an amendment at this time, and again we would suggest that the phrase in which "in health care" appears be deleted from the legislation.

The next item is the holding out clause, which is related to title restriction in a way. Holding out relates to how you could really describe what you do and who you are. Language is not strong enough in the legislation and people may be misled. The public will be confused. For example, someone could put a shingle out that says, "Audiological services." The consumer might realistically think an audiologist works there and one may not.

We are suggesting that language in our brief. You will find a suggestion that goes back to something suggested by Schwartz in the health legislation review so that the gap created by this is filled, to decrease the possibility for confusion.

It is not our intent to stop people from working. It is our intent to strengthen the legislation based on the idea that you should be able to identify individuals covered by the legislation. That is what we feel this provision would do.

Ms Kurpita: I am going to talk briefly about prescription of a personal hearing aid as a controlled act. As you know, it is an act that has been given to audiologists and to physicians. I am very happy to see that it is a controlled act included in this legislation and I strongly support the fact that it remain in this legislation.

This legislation ensures that the public is protected because hearing aids can cause harm. Some hearing aids, when they are sent to us from a manufacturer, come with a warning label stating to be sure they are not set to a certain setting because they can damage the hearing of the person who is wearing it. It is important that the hearing aids be prescribed by individuals who are fully aware of the fact that hearing aids can cause damage.

There are some arguments that if this legislation is passed as is there is going to be some access problems and a cost to health care. These arguments are not true. Attached to our brief is a survey using Ministry of Health statistics that show there is not going to be an access problem.

Currently audiologists prescribe the majority of hearing aids in Ontario. We are already doing it. This legislation formalizes what is already happening so there is not going to be any change. I urge you to keep this in the legislation. It is important for the public to make sure they are not harmed. I am sure you will have some questions about this, so we will go on to the rest of our presentation and you can ask me after.

Mr Murphy: That reaches the last of our points. I would like to express our thanks again for an opportunity to speak today and to welcome any and all questions.

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Mr Owens: I was not sure I heard you properly at the beginning of your presentation, but did you indicate that your association supports the legislation with the qualifiers you have listed?

Mr Murphy: That is correct. Overall, we are quite happy with the intent of the legislation. There are several refinements that we urge you to consider making.

Mr Owens: The AHIP people made their presentation earlier, and with their chart with respect to access to audiologists they painted a pretty grim picture of the reality now and what is going to happen a couple of years down the road. Do you see the legislation causing that type of grim prediction to come true? If not, what are you basing your figures on? The AHIP people seemed to feel the folks are not coming out of the programs as quickly as the need is growing. How do we balance the two needs, access and protection of your scope?

Ms Kurpita: One main argument is the fact that this is a controlled act given to audiologists and physicians. A physician can prescribe a hearing aid. We also have had a number of people grandfathered to allow them to prescribe hearing aids. A number of people who have been dispensing hearing aids can continue to prescribe them. There are also some audiologists who have been grandfathered to

dispensing aids. So we have a whole generation of individuals to work through and solve the problem.

There are increasing numbers of people being graduated. The Ministry of Colleges and Universities has been very supportive in making sure that some of the programs are expanding. There are more programs and there are more spaces in the Canadian universities for people to get out and to practise. We are very confident. I urge you to read the appendix to our brief, which shows that access will not be a problem.

Mr Grandmaitre: Mr Murphy, you alluded to protecting title. How come all your PhDs, no matter where they work, would like to be referred to as doctors?

Mr Murphy: I think they are probably not much different from any other segment of society where one is given an honourable title. One would like to be able to use it in situations that are appropriate. It has been something that has traditionally gone on for many years. We would in effect be putting an end to current practice. People who have worked very diligently for years towards advanced training feel this now disallows that recognition and identification.

Mr J. Wilson: It may be all very well to say that physicians under this act will be able to prescribe hearing aids, but I cannot think of any, and I know a lot of physicians, who have ever taken any courses or have really any knowledge of hearing aids other than reading the manual that comes with them. I just throw that out.

Second, you mention in your brief and in your oral submission that the non-audiologists who are currently prescribing and dispensing are grandfathered. Where is that covered in the act? I know that is the current practice, but if this act were passed, their contention is that they would be shut out from prescribing, which is the way the scope reads, the controlled act reads. How are they grandfathered if this were to pass?

Mr Murphy: Thus far, the indication we have had from ministry officials has been that this type of exemption did not need to be written. Perhaps I am mistaken, and perhaps Ms Bohnen can correct that, but it is every intent at the Ministry of Health level that this practice continue. It is not something that is contentious for us.

Mr J. Wilson: My understanding is that is not the case. I think the ministry is more worried about conflict of interest in that area and would like to narrow the prescribing or restrict the prescribing and separate it from the dispensing except in remote areas where there are exceptions made, as is current practice. I think your contention that they will be grandfathered needs clarification. Perhaps you are right. I ask, Madam Chair, that at some point this be done, that we once again clarify this point of whether or not the non-audiologists who are currently prescribing and dispensing really are grandfathered somehow in this new legislation. Certainly my reading of it does not indicate that.

The Chair: We appreciate your presentation. We may have a gap in about 10 or 15 minutes, so the ministry may be able to put that on the record today through the parliamentary assistant, if you wish.

Mr Jackson: With the point being made about challenging the contention of the cost saving to taxpayers, is it

possible for the committee to get a brief explanation or a written response to the costs for prescribing, I should say, for the audiologist, the physician and/or a hearing instrument practitioner?

The Chair: We will have an opportunity to ask questions directly of the ministry when there is time. The suggestion I have in the meantime is that they are here and if you pass them a note, perhaps they could answer that for you.

Mr Jackson: But it has been communicated that I would like that information. I am serving notice to the ministry that we would like to get that.

STEFAN FRIDRIKSSON

The Chair: Our next presenter is Stefan Fridriksson. You have 10 minutes for your presentation and we would ask you to leave a few minutes for questions by the committee.

Mr Fridriksson: First of all, I would like to say I am not presenting on behalf of any association; I am presenting on behalf of myself.

Many audiologists have expressed anger and sadness that Bill 44 will be their definition as professionals. Audiologists are the primary providers of hearing health care in this province. In diagnosing hearing impairment, we use sophisticated equipment to determine the nature and degree of hearing loss. We relate our results to the patient and the referring physician and then design an appropriate treatment program. We play the central role in public and professional education regarding hearing loss and hearing loss prevention.

As audiologists, we are required to have four years of undergraduate study, another three years of graduate school and then one year of clinical training. After eight years of study, we are granted the status of a clinically competent professional. Before we are admitted, and while we are training, we must maintain an excellent grade point average. When we graduate, we must write qualifying exams that certify our skills in the assessment and diagnosis of hearing loss as well as the prescription and dispensation of hearing aids.

How is the audiologist defined in Bill 44? While the bill recognizes the assessment of hearing loss in our scope of practice, it does not allow us to form an audiological diagnosis and relate this to our patients. In contrast, all physicians are granted the right in their legislation to use our results and provide a patient with an audiological diagnosis.

While on staff at Mount Sinai Hospital, I taught some of the University of Toronto ear, nose and throat and family medicine residents. Presumably, ear specialists should be the most qualified to disseminate audiological test results. However, they received only 26 half-days of audiological training, while the family medicine residents received just two two-hour lecture/demonstrations during which they were given the absolute minimum outline of audiology. Neither the ENT nor the family practice residents are ever examined on their skills or abilities in the field of audiology, yet they are deemed to be our supervisors in most clinical settings and can pretend that they interpret our results to our patients.

In reality, it is the audiologist who tells your mother whether she has a hearing loss, whether her hearing can be corrected by a hearing aid or whether she needs to be seen by an ear specialist for a possible medical or surgical solution to her hearing problems. It is the audiologist who tells the parents whether their child is permanently deaf or is simply suffering from a temporary middle-ear dysfunction. We are the ones who determine the nature and the degree of hearing loss and interpret the audiometric results to the patients.

As this legislation is now written, it does more than remove the diagnostic statement from the appropriate health professional; it puts our profession at legal risk. If I carry on as I have been doing for the past seven years, providing my patients and their referring physicians with the appropriate audiological diagnosis, I could be charged with practising medicine without a licence.

When I addressed this concern to some of the physicians in my area, many of them were compelled to write letters of support on my behalf. I have included copies of letters from 29 physicians. Each one recognizes the fact that it is the audiologist who interprets the results and provides the patient and the referring physician with an audiological diagnosis. As one physician stated in her letter, "It would be a complete waste of time for everyone and money for the taxpayer if all you did was send me the raw data without interpretation of your audiological assessment." It is apparent that a clause recognizing our skills would neither offend the medical community nor be an inappropriate assignment of skill.

The second problem: Subsection 15(1) of this bill states that no person other than a member may use the title "audiologist" in providing health care to individuals. Presently, there is a group of hearing aid dealers in Toronto which calls itself an audiology clinic. According to legal advice, this practice would be allowed to continue because they are not delivering their services in a health care setting. It is obvious that by using that name they are attempting to fool the public into believing they have completed equivalent training to an audiologist. This problem could easily be resolved by removing the word "health" from subsection 15(1).
1110

In terms of health care providers, audiologists and optometrists are essentially identical professions serving different physical afflictions. The first university degree programs were offered to each profession in the 1930s. Both professions developed from similar roots. Optometry grew from an offshoot of the fitters of eyeglasses called the refracting opticians and the medical body known as the ocularists, while audiology grew from the collaboration of the medical specialty of otology and from a branch of pathology known as the auditory speech correctionists.

Present-day training programs for each profession require undergraduate work in physics, biology, chemistry, anatomy, physiology, psychology and mathematics. During our professional programs, each of us studies the physics of sound or optics, the measurement of hearing or visual impairment, and then learns the correct applicable formulae for aural or visual rehabilitation.

Some comparisons made by the Academy of Dispensing Audiologists in co-operation with the American

Optometry Association point out the similarities and differences between our two professions.

Audiology typically requires the same length or one or two more years of study than optometry to receive full clinical recognition. Both audiologists and optometrists have been providing diagnostic services and prescribing and dispensing corrective devices prior to and since the birth of their professions. Both audiologists and optometrists have had periodic territorial disputes with medical professionals and paraprofessionals associated with their professions.

For two so obviously similar professions, the differences between the present legislation being offered to each is stark. Optometrists were granted full title protection, dispensing rights, diagnostic statements and a raft of definitions of territory regarding treatment, use of diagnostic tools, and assessment. Conversely, audiologists, using the equivalent tools and performing the equivalent tasks, were granted a status equivalent to a technician. We ask ourselves, how can it be fair when one profession that is so obviously of the same calibre as another is granted so much while the other is granted so little?

Is it because optometry has 870 members while audiology has only 250? That would be as unfair as granting obstetricians/gynaecologists more status than ophthalmologists. They presently enjoy equal but different status because the only difference between them is that they apply their skills to different but equally important parts of the body.

Is it because the ears are somehow less important than the eyes? Obviously not to one of my clear-sighted hearing-impaired patients. Is it because we are under-qualified, under-examined or under-scrutinized? Both of our professions have national bodies that set national exams, standards of ethics and practice and each of us has agents of the federal and provincial governments that monitor our conduct.

Is it because audiology is dominated by females—82%—while optometry is dominated by males—76%? I hope not. Is it because optometry was previously recognized by legislation? I thought the idea of this legislation was to seek out fairness. Is it fair that because you forgot us last time you should ignore us again?

Optometry and audiology are scientific and technical skills applied to the health care field. We both wanted fairness from this process. Only one of us got it.

I have come to the end of my presentation. After I read this to my wife, she asked: "How did it ever get this bad? After all those years of study, we owed over \$35,000 in student loans. For seven years you were never home because you were always studying at the university library. Now, after all this, they tell you the only thing you know how to do is prescribe a hearing aid."

I am asking the members of this committee to change that. I am asking you not to perpetuate the privilege of the old boys' club that prevents the legitimate recognition of the contributions that the men and women of my profession make to the health care field.

Simply stated, audiologists are asking for two changes to this legislation: a diagnostic clause that allows us to relate our findings to our patients and to other health care professionals; and changes to our protection of title, in

order to prevent others from using our name outside the traditional health care setting.

Mr J. Wilson: Extremely well done. Now, you are currently indicating the diagnosis to the patient.

Mr Fridriksson: Yes, I am.

Mr J. Wilson: Just for the record, why are we being asked to restrict that practice?

Mr Fridriksson: I do not understand it. I have letters from 29 physicians and I am expecting more by fax. Unfortunately, I had to leave before my fax machine got them this morning. I am expecting faxes from places up in the north and various other physicians in my area, saying I am the one who diagnoses hearing impairment. I do not understand where the process got lost.

Mr J. Wilson: In the one quote you do cite from a physician, though, that is communicating between professionals. It is our understanding from the ministry that this would not be prohibited.

Mr Fridriksson: Okay, can you read maybe in your spare time? There are about 29 letters here. Just take a glance through some of the letters. They say: "I recognize that you say this to my patients. I recognize that you are the qualified one and I am not trained in this area."

Mr J. Wilson: We have heard this from a number of witnesses, and we certainly are going to take a serious look. It is my understanding we are trying to get rid of the non-regulated quacks out there, if there are any, from communicating diagnoses, but in your case there seems to be very good evidence brought forward. If that is the current practice and people are not being harmed, and the medical profession is supporting you on that, we will certainly take a look at it.

Mr Fridriksson: Could I address some questions? People were talking about harm of hearing aids and they were also talking about prescribing. You were talking about access. One of the people cancelled—

The Chair: You are going to have to submit that in writing to the committee.

Mr Fridriksson: One of the people right after me cancelled. I was wondering if I could use a tiny bit of that time to address the question from Mr. Sola.

The Chair: No, I am sorry, you cannot.

Mr J. Wilson: She cuts us off too.

The Chair: It has been noted and we will have an opportunity to have those comments addressed. Perhaps they can be discussed at committee. If you hear anything you would like to submit in writing, that would be very helpful. Thank you very much for your presentation.

Mr Fridriksson: Okay. Thank you.

The Chair: We have approximately five minutes before the next presentation. There was a question that was posed to the ministry, and I will undertake a list. Mr. Jackson, you had a request. Do you want to start out first?

Mr Jackson: I think they are aware of my request. I know they cannot give me the details I am looking for verbally, so if we could get that in writing, I would appreciate it.

Ms Bohnen: Could you just restate what the request was? I think it was that you were interested to know the relative cost of a physician and audiologist or hearing aid dispenser diagnosing hearing loss? Is that how you put it?

Mr Jackson: And prescribing. I would like to see the contention from the Canadian Association of Speech-Language Pathologists and Audiologists; they challenge the notion that it would be less expensive, and I would like to see a breakdown of the fee structures and how they are paid. I would like to know the difference between those which are regulated through order in council from the assistive devices program versus those which may be a fee that is negotiated through the OMA, and other fees. I would like to know how they arrive at their fee, who controls the fee and when it is paid by those three groups. If that is the turf war we are looking at here, I would like to look at the financial breakdowns and I will draw my own conclusions about what is going to be cheaper or more expensive for taxpayers in Ontario.

The Chair: Comment or question, Mr Cordiano, and then I have Mr Owens, and we have four minutes.

Mr Cordiano: I have a question of the ministry with respect to the last brief, and it centres on the whole question of the audiologist diagnosis versus—I would imagine what you outlined for us previously was the question of diagnosis versus assessment, and essentially the audiologist is making an assessment, in your opinion, and the way the new legislation is crafted, that would be essentially an assessment versus a diagnosis. Is that correct?

Ms Bohnen: That is correct.

Mr Cordiano: What we then have to take is that one step further and how that assessment would be relayed to the physician, who would then make a diagnosis?

Ms Bohnen: It would not necessarily go in that sequence. I think what you have heard is concern from this group and previous groups that their assessment activity, including communicating the result of the assessment to the patient or client, would be unnecessarily and wrongly interfered with by the diagnosis controlled act. The issue I think comes down to how that diagnosis controlled act should be worded, and depending on how it is worded in the end, whether such things as clarification of the right to assess and communicate the assessment is necessary, or perhaps whether other groups do perform diagnosis, however it is finally worded. That is the area we are talking about sorting.

Mr Cordiano: But certainly you are making me come to the conclusion that it was not the intention of the minister to exclude, for example, the audiologist from making his or her professional, shall we call it, diagnosis or assessment.

Ms Bohnen: There was absolutely no intention to stop audiologists or speech-language pathologists from assessing their patients or from directly communicating the outcome of the assessment to the patient. There is no requirement intended that they should have to use the physician as the intermediary.

Mr Cordiano: All right. So it is a question of clarifying that. Thank you.

The Chair: Mr Owens, one minute.

Mr Owens: I guess Mr Cordiano and Mr Jackson have both touched on the questions in terms of the different cost scenarios with respect to restricting one's ability to diagnose and prescribe and then for allowing the status quo. Has the ministry taken a look at different cost scenarios around that, and if you have, can we see those?

Ms Bohnen: These recommendations that Schwartz made and that are incorporated in the legislation do not result directly from cost scenarios but rather a risk of harm to patients and ensuring quality care. But leaving that aside, I believe it is quite possible to provide the information you are looking for, which is I think partly, with these participants in the hearing aid service area, what are the costs associated with different participant groups playing different roles.

One thing that I think complicates the analysis a little bit is the fact that during the course of Schwartz and the translation through legislation, the assistive devices program generated policies so that provincial moneys in the funding of hearing aid services would be properly spent. That changed the manner in which most hearing aid services were provided in Ontario, but it still should be possible to come up with the information you are looking for and we will do that.

The Chair: We will have to continue this discussion at another time.

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ARNE JENSEN ZABELL

The Chair: Our next presenter is Arne Zabell. Welcome to the standing committee on social development. You have 10 minutes for your presentation and we would ask that you leave some time for questions at the end.

Mr Zabell: Madam Chairperson, honourable members of the committee, my name is Arne Jensen Zabell. I am severely hearing-impaired. I wear two of the most powerful hearing aids you can get. Beside me is my wife, Pamela Zabell. She is also a hearing aid specialist. She is here to channel me when I misunderstand what you say to me, because even with hearing aids there is a tendency to misunderstand even when you can hear. Hearing and understanding are two different things.

I am a certified hearing aid specialist graduated from Sheridan College in 1980. I have a certificate from the national hearing aid society that calls me a hearing-instrument specialist. The Ontario Ministry of Health assistive devices calls me tester-authorizer and vendor. I own and operate Zabell Hearing Aids in Hamilton and Hagersville. I am the only health care professional who guarantees satisfaction or money refunded. I have told you this so you will understand I have knowledge about the subject.

I am here because I think you are making a mistake if you proceed with the bill as it is written. You have an opportunity to make the best audiology bill in North America if you will just use some of the German ideas. To do it complete

justice, you should go to Germany and study their structure or invite somebody knowledgeable to testify.

Consider this. Only a very small percentage of hearing-impaired can be helped medically or by surgery. Therefore, at the entrance into the system there should be a screening procedure, such as a simple audiological test that could be done by a second-year audiologist, who could be called a hearing aid specialist. They could decide if referral to an otolaryngologist or clinical audiologist were indicated. If not, then take them directly to a hearing aid evaluation. That alone would save thousands of dollars and ping-pong trips from place to place would not happen.

To make it work, consider tiering audiology. Two-year students of audiology should learn about hearing aids, including practicum. Four-year students would be clinical audiologists but would lose hearing aid designation if they did not practise or attend updates.

It is impossible for a clinical audiologist who spends much time doing brain stem tests and such to keep up to date with the new hearing aids and it is unnecessary for a hearing aid fitter to know brain stem testing except to know when to refer. But they have a large pool of common expertise and therefore belong in the same college, both for the sake of equal progressive learning and cost benefit to the taxpayer. The common bonds between an audiologist and a hearing aid specialist can be stated more easily than the unnatural union of speech pathology and audiology. The audiologist association and the Association of Hearing Instrument Practitioners of Ontario should be forced to amalgamate. The government of the day saw nothing wrong in encouraging the Sheridan graduates' association to amalgamate with the hearing aid fitters for the betterment of the system. Now is the time to go the last step and write the legislation in such a way that there will be no more turf wars and the hearing-impaired and the taxpayer will be better served.

There will be moans and groans from both sides, but the fact is that very few clinical audiologists understand or keep up with the dozens of new hearing aids that come on the market every year, and they have tried to use an equal-loudness measure to fit air pressure hearing aids. If we get everyone into the same thorough schooling, the result will inevitably be better instrumentation, which in turn will give us better hearing aid fitting, and the audiologist in the first two years will learn all about hearing aids and ear molds and learn the use of an otoscope.

The audiologist will gain by a closer association with the hearing aid fitters, and the fitters will gain from expanded knowledge of audiology. The hearing-impaired will gain from an expanded pool of knowledge. The medical profession will undoubtedly approve, as they are already tiered into specialists of the same profession. The taxpayers will gain by only having one school to pay for, and there will be only one professional organization to go to for discipline when there is a complaint. It is totally a win-win-win situation.

As I see it, it will be a sad day if we lose this opportunity to make the best possible system for the hearing-impaired.

I have spoken to some audiologists about this idea. They say, "It isn't a bad idea, but please don't tell others I said

that." I have talked to some hearing aid specialists about it, and they have agreed but said, "Don't quote me, I might be cut off from my referrals."

The past 10 years have seen an improvement in the services to the hearing-impaired. You have the opportunity to improve this bill and set an example for all of North America by improving Bill 44 by the simple method I have suggested. I thank you for the opportunity to give you my ideas, and in the right-hand side of the folder I have the papers which prove what I said.

Mr J. Wilson: A great brief. I particularly appreciate the recommendation to travel to Germany.

But on a serious note, if I understand this, the audiologist is in university for four years doing an undergraduate degree in sciences. You are recommending that the non-audiologist now—it sounds like the corollary would be that they would have to take at least two years of equivalent, two years of university, which would be equivalent to the first two years an audiologist would go through, which would mean a cursory review of the sciences, I would think.

Mr Zabell: I have included in my explanation this McSpaden report, where everything is explained by a professor who can do it much better than I can. I included that in there to answer whatever questions you have and who knows what, where and when.

Mr J. Wilson: Okay, sorry. I did not see that. I will be sure to read that.

Mr Owens: I concur with Mr Wilson that perhaps a look at what happens in Germany is a good idea. I did not get a sense in your presentation of whether you agree with the legislation as it is proposed. Do you think it is a good idea, and have you approached the AHIP people with respect to merger?

Mr Zabell: I have spoken to them, but they say, "You know, when you hear two different stories, the truth is usually somewhere in the middle." That is what I come with in this presentation. I wanted to make this presentation because I really deeply feel—and I am hearing-impaired myself—I would like to see the best possible system, but as a taxpayer I certainly do not want to blow my money, because taxes are high enough as they are.

I am a member of the association, and undoubtedly a lot of different things are going to come up from my presentation, why I could have said this and why I could have said that. I tried to explain that in here.

I also have another thing in here about the jail term if I tell somebody that he has a hearing loss and he needs something. I have an explanation of that in here too. My whole object is to get the best possible for the hearing-impaired, since I am hearing-impaired, and the cheapest possible, because I am a poor taxpayer.

Mr Martin: I find your thoughts rather intriguing and interesting, to say the least, and I do hope that those who practise in the field of audiology will sit down with you and look at that. I think it will be helpful for those of us here who struggle with the final version of what this legislation will look like for you who work in this field.

The minister, when she was here last week, said that this was living legislation; it is evolving. Certainly, the whole

delivery of health care in Ontario is evolving very dramatically in many ways.

I would suggest that if, in fact, the legislation goes through without those corrections in it that you suggested today and what some of the folks who presented earlier suggested, both from the audiology and the hearing instrument professions, you continue to talk and that you come up with some things within that structure which will be in place to look at the evolution of how we deliver services, that you will participate in that discussion and allow this whole field to evolve as it should, to take into account those things that you presented today, because I think you present here the beginning of a coming together of two professions that have served us well to this point, and somehow we should be looking at a way to involve everybody.

Mr Zabell: I certainly appreciate your comments.

1130

PAULA SQUARE

The Chair: I would call now Paula Square. Welcome; you have 10 minutes for your presentation.

Dr Square: Madam Chair and members of the standing committee, I am Professor Paula Square, chair of the graduate department of speech pathology and director of the division of speech pathology, faculty of medicine, University of Toronto. I hold the degree of doctor of philosophy in speech pathology, and am both an academician and practitioner.

I am most appreciative of the opportunity to address the committee today to present my thoughts concerning Bill 43. The overall intent of the bill, the protection of the public with regard to health care, is laudable.

In its current form, however, several sections may in fact disadvantage the public. Those same sections would be dramatically harmful to the present practice of speech-language pathology and the future of this health care profession, which is one of several designated by the Ministry of Health as a top priority for development.

My primary concerns are two: the restriction of the use of the title "doctor" in health care settings, section 30, and communication of diagnosis of disease, disorder and dysfunction to a patient or a patient's representative, section 26.

Consideration of subsections 30(1) and 30(2) will be addressed first. The bill, as currently worded, explicitly disallows all allied health care professionals holding the doctor of philosophy degree, with the exception of psychologists, to utilize their duly earned and university-conferred academic credentials of PhD when in the health care setting.

If passed, Ontario will be distinct in North America and most probably the world in that our government will have effectively (1) infringed upon the rights of patients to know the degree status of all health care professionals from whom they receive treatment; (2) altered the historic and internationally accepted academic principles of the use of title "doctor" by individuals holding the PhD regardless of professional environment; (3) negatively influenced the ability of the universities within Ontario to recruit PhD candidates into the allied health fields in which they are most desperately needed; and (4) fostered discrimination against women in that many of the affected health care fields are female-dominated professions.

Most surely it was not the intent of the writers of this bill to promote such negative effects. Most surely it was not their intent to create further obstacles to the development of those health care professions which this ministry has designated as top priorities for development. None the less, subsections 30(1) and 30(2) do just that in their present form. I urge you to consider the above points carefully, and most humbly I offer you the following recommendation for rewording:

Any person who has earned a PhD in a discipline whose scope of practice includes the provision of health care should be allowed to use the title "doctor."

It is also my desire that this committee reconsider subsection 26(2), that section of the bill which deals with the communication of diagnosis of disease, disorder or dysfunction.

A major role traditionally assumed by practitioners of speech-language pathology is the diagnosis of speech and language pathologies. The name of our discipline, speech-language pathology, denotes this role—the responsibility to diagnose disorders and dysfunction of speech and language, and to subsequently communicate to the patient or his/her representative all pertinent information concerning the nature, underlying causes, management recommendations and a prognosis.

Section 26 of Bill 43, if accepted in its present form, will effectively change the nature of the profession of speech-language pathology and alter the scopes of practice of this discipline.

As the head of an outstanding graduate professional training program in speech-language pathology in North America, as the person who is ultimately responsible for the curriculum of this graduate program, and as an academic administrator in the faculty of medicine and school of graduate studies at the University of Toronto, I can state categorically that no other health care profession can communicate better to an individual with a speech and/or language disorder the nature of his speech-language pathology; no other health care professional can diagnose as accurately the disorder or dysfunction of communication; and no other health care professional can prognosticate better as to the future course of the communication disorder/dysfunction.

As an active participant in both administrative and academic matters in the faculty of medicine, I can also state categorically that while medical students are trained in a superlative manner with regard to the nature, diagnosis and treatment of diseases, they are not adequately trained to assume those scopes of practices for which speech-language pathologists are trained.

The depth and breadth of the requisite knowledge base which physicians must acquire with regard to disease processes and the diagnosis and treatment of disease precludes their becoming knowledgeable in all aspects of health care, and most certainly precludes their abilities to assume the roles of other health care practitioners.

The terms of section 26 of Bill 43 would place physicians under inordinate demands to acquire both the academic and practical knowledge required to assume the role of informant and counsellor about the nature of communication

and its disorders, skills which speech-language pathologists acquire over two to three years of graduate education.

The scopes of practice for the profession of speech-language pathology includes diagnosis, communication of a diagnosis and counselling, and have been clearly defined in a publication by the Department of National Health and Welfare.

All seven Canadian graduate training programs address fully these scopes of practice in their curricula.

The current wording of Bill 43 would redefine both the professions of speech-language pathology and medicine.

I humbly again offer the following recommendation as a revision: "All regulated health care specialists may communicate to patients and their representatives information relevant to the patient's disease, disorder and dysfunction as specified by the scopes of practice of their respective disciplines."

1140

Mr Owens: Thank you, Dr Square. I guess I can still say that without getting into trouble. One of the things that we are trying to sort out on the committee, and we heard a number of people from your profession last week who expressed the same sentiments with respect to the title "doctor," is whether there is confusion or whether there would be confusion in the mind of the consumer around exactly what specialty with standing is presenting itself to the patient. Have you, in your experience, had any difficulty with that, or any of your students?

Dr Square: I have not had that difficulty. I was at Mayo Clinic for several years and none of my patients at Mayo ever confused me for a physician. My name tag said, "Paula A. Square, PhD, speech language-pathologist." If you are concerned about the confusion, then I query why psychologists could designate themselves as doctor, if that is your query.

1140

Mr Owens: One of the things that was suggested is that we take a look at perhaps the regulation on name tags or some level of identification indicating "Dr Square, PhD, speech pathologist." That seems to be the standard in the field, at this point anyway. Would that be acceptable to yourself and the folks you represent?

Dr Square: Most certainly. Of course "PhD" does designate the designator of "doctor" in formal communication.

Mr Cordiano: What you are recommending is that we use the title "PhD," which would be satisfactory, as opposed to the actual use of the word "doctor" in the title.

Dr Square: Yes, but in informal communication worldwide, the holder of a PhD is referred to as "doctor" in verbal communication.

Mr Cordiano: Yes.

Mr J. Wilson: Along that line, I do not see how this Legislature or any other could prohibit that.

Dr Square: That is right.

Mr J. Wilson: A PhD is a PhD. It is the highest degree earned in academia. I do not know which group of legislators along the way gave "doctor" to optometrists, but we are on a political slippery slope. We are giving the term which is

held in high esteem by the public to essentially undergraduate degrees and technicians. I am certainly sympathetic to your wishes in that area. I do have one quick question, though.

The Chair: Thank you, Mr Wilson. Time is up.

Mr J. Wilson: He got my supp. I am going to ask this question now.

The Chair: But you made a speech.

Mr J. Wilson: I learned it from a particular party that was in last time.

The Chair: I am going to have to ask that you ask your question of the witness outside, as time is up.

BARTON SALA

The Chair: The next presentation is from Barton Sala. Welcome to the standing committee on social development. You have 10 minutes for your presentation.

Ms Sala: I am not here as a professional practitioner. I am here as a user and a very successful user, I think. I wanted to make a few points about my experience with speech-language pathology.

A few years ago, for many reasons—not the least of which was a terrible cold—I lost my voice. For all intents and purposes, I sounded as though I had laryngitis all the time; I was hoarse, I was raspy. It was particularly troublesome to me because I use my voice professionally. I make presentations often. I am on the phone a lot for my work. I attend an awful lot of meetings, public and private. I also do recordings, videotape and audiotape recordings. So it was not just annoying to have this speech difficulty; it was making my work very, very difficult.

I went to an ear-nose-throat doctor thinking that perhaps I had stress nodes, something physically wrong with me that could be easily or surgically corrected. I went to the doctor. He took a case history, ran some tests, and reached a conclusion. The conclusion was that there was nothing physically wrong. While things were not really wrong, they certainly were not right either, because nothing seemed to be working correctly. He thought that I could probably benefit from speech therapy and he sent me to a speech-language pathologist.

When I went to the speech-language pathologist, similar circumstances took place. She took a case history—what was my health history like, what was my speaking history like. She ran a battery of tests—different tests, but a battery of highly sophisticated tests—and she reached, as well, a speech-language diagnosis that while certainly nothing was physically wrong, there was an awful lot that I was doing wrong.

You are probably not interested in the techniques and things, but I was not breathing properly, I was not holding my throat properly; just a battery of things that just were not going very well. She discussed that with me. She told me various ways that I might have become this way, and there are many, many reasons. You get used to talking a certain way, especially if you have a bad cold and you are forcing your voice. You might be speaking incorrectly and this then becomes habitual and difficult to stop.

She discussed it in great detail and at great length. She talked about what the therapy was actually going to be. I

entered into quite a lengthy and interesting and difficult set of meetings with her where she worked as hard as I did and probably harder—breathing exercises, speaking exercises. It was very, very thorough.

I guess if you could stand back from it, it was a fascinating experience. But in any event, after several months of this, I considered myself to be, if not perfectly well, much, much better. I am now back reading presentations and recording my voice and all that sort of thing, and I feel much better about it.

Out of all of this, I just wanted to make some points, because I really do feel it is important. I probably would not have, except that I am so delighted with what went on. When the doctor told me I should seek speech therapy, I had heard of speech therapists but I was not really familiar with speech-language pathologists. I do not think people walking down the street can think about speech-language pathology, although they often consider speech therapy.

I think it is important to make the point that those two titles are absolutely synonymous for people.

I did not say to people at work, "I am visiting a speech-language pathologist." It takes too darn long to say, and nobody knows what it is. I was seeing a speech therapist, even though she was a pathologist with all the education and training and everything that goes into that. So I wanted to let you know that I think speech therapists and speech-language pathologists are synonymous, certainly with lay people like me.

I also want to make another point, that I think it is vital that this consistency of association be province-wide. I know that if I go to a dentist anywhere in the province of Ontario, there are going to be certain qualifications; there is going to be a certain education level; that any dentist is going to give me at least the same basic treatment that I require. I have confidence in that. In fact, I went to a dentist who is not mine this morning for an emergency, with full confidence that I was going to get the kind of treatment I needed, because that person called himself a dentist. I think that is an important point.

The other point I wanted to make, possibly more important but maybe just on a different slant, is that it was extremely important that the woman who ran the tests and did the diagnosis was able to sit down and discuss it with me. It means that I began to trust her a lot more quickly than if I had had to go somewhere else for an interpretation of the tests. She ran the tests. She talked to me about what the tests were, what they meant, what the results were, what those results meant, and what the treatment was going to be.

I think that is something that absolutely cannot be taken away, that ability to communicate with me or anyone else.

I just cannot imagine what it must be like—well, I can imagine. We have all been for X-rays, we have all been for other tests; you see five or six different people, none of whom tells you anything. Finally you get bounced back to another doctor, who sits there, looks at your tests and says: "Gee, I am not really sure what all this means."

I would like the person who does the tests and who is going to treat me to discuss them with me. I think that is very important.

That is really all I have to say. I was hoping to be very brief today. If you have any questions, I would be more than happy to answer them for you.

Mr J. Wilson: Are there many people, in your experience, holding themselves out as speech therapists who are not qualified as speech-language pathologists?

Ms Sala: My experience is limited to one person.

Mr J. Wilson: Have you heard any horror stories?

Ms Sala: No, I have not, probably because any of my peers who have sought the same kind of treatment have gone to speech-language pathologists.

Mr J. Wilson: They were aware of what they wanted and sought a speech-language pathologist.

Ms Sala: Somebody with very solid qualifications. If your voice is important to you, the treatment of that voice is important to you as well.

1150

Mr Owens: So in terms of a practitioner, you would look for somebody using the title "doctor"? You have probably been listening to some of the discussion around the use of the term "doctor" for PhDs. Would that, in your mind, present any confusion, or would you prefer seeing a person with the title "doctor"? How do you feel as a consumer?

Ms Sala: Certainly as a consumer—we are so trained, when we see "doctor," we see all of these—

Mr Owens: We see excellence, allegedly?

Ms Sala: We see certain qualifications. We see certain experiences and certain levels of training that lead us to believe there are certain levels, so "doctor" is always helpful. But knowing that speech-language pathologist A and speech-language pathologist B are going to have the same basic qualifications—let's put it this way: Would I like my speech-language pathologist to be a doctor?

Mr Owens: On a scale of 10, where would you put it in terms of concerns?

Ms Sala: It is something I have never really considered.

Mr Owens: Do you really care?

Ms Sala: I think, for other people who do not take the time to investigate, perhaps "doctor" would help. "Speech-language pathologist" says to me an awful lot of medical knowledge. Perhaps "doctor" would round that off, I am really not sure.

Mr Hope: When you see the title, not necessarily the word "doctor," but "speech-language pathologist," you know there is an academic level or degree of education involved. That is all you are concerned about. You do not want the title and then two different academic levels involved. You do not want one having a higher level of education than the other?

Ms Sala: The doctor and the speech-language pathologist?

Mr Hope: No, get rid of the "doctor." Now look at the speech-language pathologist. What you want to do is make sure that the level of education is the same for all. You referred to dentists; speech-language pathologist would be at the same level. You do not want two levels of education involved, where one down the street would have a higher education than the one across the street.

Ms Sala: That does not bother me, as long as the lower level of education meets the standards for that particular profession.

The Chair: Thank you very much for your presentation.

Ms Sala: Thank you very much.

The Chair: The committee has seven minutes available till we adjourn at noon. Mr Owens, you had some questions of the parliamentary assistant. We cut you off last time. Did you want to continue that live discussion now?

Mr Owens: My questions were essentially around the cost comparisons between restriction and status quo; the ministry staff indicated that it is possible to provide them.

A further question on a totally different topic: I wonder if there is available an explanation or a rationale why the title "doctor" was restricted to the groups that are now currently within the legislation. I do not understand why all of a sudden it has changed. We have restricted it to certain groups, and we have other groups out there that are clearly able to use it and have earned the title through academic study.

Mr Wessinger: I think I will refer that to the ministry staff. I would assume that it is based on the traditional use of the term.

Ms Bohnen: The review inherited a landscape in which physicians, dentists and optometrists were permitted to use the title "doctor" in the course of providing health care, optometrists having acquired that right with the Health Disciplines Act in 1974. Prior to that, only physicians and dentists could use the title "doctor" in the delivery of health care.

As the review developed, the criterion to determine which additional profession, if any, should be granted the statutory right to use the title "doctor" during the provision of health care was primarily whether a degree or diploma that said "doctor" was the entry-level academic requirement for practice of the profession. The two additional professions which met that criterion were psychologists and chiropractors.

To register in Ontario to practise psychology, you must have a PhD. To register in Ontario to practise as a speech-language pathologist in the future, once the legislation is enacted, in all likelihood the basic entry-level requirement will be a master's level of preparation. Some practitioners do have PhDs, but the entry-level requirement which all practitioners must have is not the PhD.

A PhD is the requirement for psychologists, and a diploma with "doctor" in it is the requirement for chiropractors. Coupled with that, I think, was the issue of common usage attached to these professionals in the course of providing health care.

Does that help you?

Mr Owens: Looking at speech-language pathologists in particular, I am just wondering how it would upset precedent if the committee recommended that speech-language

pathologists, as an example, were allowed to use the title "doctor" if they had reached the PhD level.

Ms Bohnen: You may recall the review also recommended there be an exception permitting anyone who worked in a regulated setting like a hospital, or university, I suppose, to use the title "doctor" if they had it. They felt that the management of those institutions would ensure there was no patient confusion.

Currently, from what we heard this morning, a speech-language pathologist with a PhD works in a hospital or wherever; the name badge says "Linda Bohnen, PhD, speech-language pathology." That will not stop. The new legislation does not restrict in any way the use of the letters "PhD."

In informal communication, some patients might say "Dr Bohnen," and others would say "Miss" or "Mrs" or whatever they chose. It is hard to imagine much enforcement should they use the wrong prefix to my name.

Mr Cordiano: I think it is a question of where we are drawing the line. In the case of speech-language pathologists, there are those who do not have PhDs who are practising as speech-language pathologists. To have two levels of practitioners, which would be viewed as two different professional designations, is a bit of a quandary, if you will, for people who would then perceive one to have a PhD degree and another who might have a master's. You are going to create two tiers. Is that what the concern is?

Ms Bohnen: That is one concern. But the concern that primarily motivated the review to limit the use of "doctor" was that most Ontarians still think "doctor", unless they are in a dentist's office, means "physician." The consumer whom we just heard from said she went to her doctor. Her doctor referred her to a speech-language pathologist.

The review's primary concern was that people think "doctor" means "physician." If we let other practitioners, especially those practising privately outside settings where there is responsible management necessarily in place, they will think they are being seen by a physician when they are not.

Mr Cordiano: We are making it worse. I think I am going to throw a wrench into all of this and say that we should have restricted the terms to medical doctors. That would have simplified everything. It is too late now because we have come along that slippery slope. There have been many, many years of usage of those terms by dentists, by optometrists, and it is now very confusing.

As for concern for the consumer, we do have a confusing situation on our hands, so I think we have to draw the line with a view to the use of the term "PhD," which is what I would recommend, and that is not restrictive. You still have a real mess on your hands as far as I am concerned.

The Chair: The committee now stands adjourned until 2 o'clock this afternoon.

The committee recessed at 1200.

AFTERNOON SITTING

The committee resumed at 1400.

The Chair: Good afternoon. The standing committee on social development is now in session. We have agreement from the Progressive Conservative caucus to begin promptly at 2 o'clock. The parliamentary assistant is here.

I understand there is going to be a joint presentation, or one following the other. The Board of Regents of Chiropractic will be followed by the Ontario Society of Chiropractors. I understand you have a video presentation. Would you introduce yourselves for Hansard. I understand there is an agreement with the Ontario Society of Chiropractors that you will have a total of 25 minutes in your presentation and it will have 15 following. In total, there will be a 40-minute presentation with questions and answers at the end of the two presentations. Is that agreed?

Mr Springer: Actually, after my verbal presentation we would prefer to separate the questioning. We will show the video in our part of the session, I will make a verbal presentation and we can respond to questions.

The Chair: In that case, as the agenda shows, there will be 20 minutes for each association and we ask you to leave time during your 20 minutes for questions.

Mr Springer: The society has agreed to give up five minutes of its presentation because of the length of the video.

The Chair: In that case, you will have 25 minutes and they will have 15 minutes.

BOARD OF REGENTS OF CHIROPODY

Mr Springer: My name is Andrew Springer. I am here to make a submission to the committee on behalf of the Board of Regents of Chiropractic, the regulatory body of chiropractic and podiatry. Accompanying me are Neil Naftolin, a member of the board, and Peter Wilson, who is the chief of the Ontario chiropractic program. Unfortunately, our chairman, Dr Diana Schatz, is unable to attend due to the unfortunate passing of her father, Roland Michener, last week.

During the preparation for this presentation, and very commonly in years past, I have continually encountered misconceptions regarding the function and the role of chiropractors in the health care system. It has become increasingly evident that there is a lack of understanding about what it is that chiropractors do. This state of affairs is not surprising. Most people will not have encountered a chiropractor and many have never heard of the profession.

In 1984 the board registered 150 practitioners, 34 of whom were chiropractors. In 1991 there are 319 practitioners registered with the board, 218 of whom are chiropractors. Compared to other professions which will be making submissions here, this represents a very small group. Many of you will not have had any direct contact or experience with chiropractors. To that end, our presentation is designed not only to allow for suggestions that we have to make regarding the Chiropractic Act, but also to elevate chiropractic from the conceptual level closer to a concrete reality, therefore providing you with another frame of reference for discussion.

With your indulgence, I will display a brief video which the Ontario Society of Chiropractors has agreed to include as part of its presentation. They are sacrificing, as you know, some of their time to allow for the showing of the video. The primary function of the video actually is for the recruitment of potential students, but I believe it will provide you with a broader understanding of what the profession of chiropractic has evolved into.

Following the brief video, I will make my comments about our position on the act.

[Video presentation]

1415

Mr Springer: Thank you very much for your indulgence. I hope that was informative for you. The board is very pleased that the Regulated Health Professions Act and its companion acts have reached this point in the legislative process. Certainly, in many ways, Bill 43 and Bill 45, the Chiropractic Act, represent a significant improvement over the existing Chiropractic Act, which, except for regulations, remains unchanged from its original form in 1944.

We strongly endorse Bill 45 with one single suggestion for change. We believe the communication of a conclusion identifying a disease, dysfunction or disorder of the foot is an essential authorized act for chiropractors. We believe the nature of the authorized acts that chiropractors will perform—that is, cutting into the subcutaneous tissues of the foot, administering substances by injection into feet and prescribing drugs—requires such communication.

Every patient is entitled to informed consent to understand the nature and cause of their condition, the treatment of choice and the alternatives. Without the right to communicate this information, the patients will not be fully informed. There has been some question as to the ability of chiropractors to actually provide this information. The education and training of chiropractors is designed to develop their powers of deductive reasoning, to allow them to come as close as possible to the cause of a problem and then to provide the appropriate care.

This training, of necessity, has developed partially in response to public need and also in response to existing legislation and regulations which require presently that chiropractors furnish a diagnosis as part of each patient record. Included in our written submission is a list of chiropractic-specific diseases and general systemic diseases which manifest themselves in the lower limbs. These are commonly seen in the practice of chiropractic and are taught as part of the chiropractic educational program.

Chiropractors now provide approximately 250,000 patient visits per year in publicly funded clinical settings. This represents a very real saving in tax dollars because of the number of seniors particularly who are kept ambulatory as a result of their treatments. There is an impact on their physical and emotional wellbeing. Their ability to move around freely allows many to maintain a measure of independence and self-esteem that most of us do not value until it is threatened.

Being unable to diagnose will change the nature of the practice of chiropractic. Recognizing the right of patients to full disclosure of information regarding their condition and treatment, chiropractors would have to refer patients back to their physicians to have the doctor relay information already discerned by the chiropractors and then send the patient back to the chiropractors for treatment. If this procedure is projected over 250,000 visits, with allowances for the continual growth of chiropractic in Ontario, this translates into millions of dollars spent at no increased benefit to the consumer.

You may ask why chiropractors, above other professions who are seeking the same change in their acts, should be allowed to diagnose. Chiropractors are primary care practitioners. This means they commonly see patients without a physician's referral. It is reasonable to assume that when a physician refers a patient to another health practitioner who is not primary care, a communication has already been made regarding the nature of the patient's condition. This permits the patient to make an informed decision about his or her treatment. This assumption cannot be made about a patient who attends a chiropractor.

By including this controlled act in the Chiropractic Act, you will be ensuring that patients are fully and accurately informed by trained personnel, thus facilitating informed consent.

In summary, the Board of Regents of Chiropractic strongly urges you to seriously consider augmenting the list of authorized acts accorded to chiropractors in Bill 45 to include the communication of a conclusion identifying a disease, dysfunction or disorder of the foot. We feel that this is justified because the public has a right to informed consent; because this is not an expansion of the scope of chiropractic practice but accurately reflects the training and practice of chiropractic as it has existed in Ontario for quite some time; because there is a foreseeable increase in the cost of what is now a very cost-effective service to the province's population; and because there is a legislative precedent in existence—specifically, the regulations of the present Chiropractic Act, 1944.

I thank the committee for its attention and hope that you will give our arguments every consideration. We will be glad to answer any questions you may have.

1420

Mr Owens: That was an excellent presentation, Mr Springer. I have a question around your requested amendment, in that the video we saw was basically Toronto centred. Have any morbidity and mortality studies been done in areas where chiropractors are available versus areas where they are not, with patients who have circulatory problems as a result of diabetes or any of the other illnesses that would affect the feet?

Mr Springer: I believe there have been some preliminary studies. Mr Wilson might be able to respond to that.

Mr P. Wilson: To my knowledge, there have been no such studies specific to chiropractic. However, I understand there have been studies conducted which would lead one to the conclusion that if chiropractic were introduced to that particular geographical region, there would certainly be an

impact and a need for that type of service and it would in fact enhance the health of the local community.

Mr Owens: What happens now in some of the more remote areas where a chiropractor may be available but a physician is not available? Is the assessment and diagnosis made and passed on to the patient? Would this legislation be a change to current practice?

Mr P. Wilson: First of all, with regard to current practice, since the introduction of chiropractors into the province in 1982, physicians have not been involved in the referral of patients to chiropractors, nor have they been involved in the diagnosis of conditions of patients received by the chiropractors. The role of the physician has been that wherever there has been a designated physician in a particular hospital who would take an interest in chiropractic, his or her responsibility has been to represent the chiropractic department at the medical affairs level of the institution. It has been purely administrative.

Also, to help smooth the introduction of this essentially new profession or health discipline into the hospital, a physician has usually been identified but not in all cases. The relationship is not one where the chiropractor cannot operate independently.

Mr Cordiano: My question is probably directed at the ministry, but I would also like to direct my question to the presenters with respect to the point they make on the degree of sophistication of service they provide in the controlled act. Your suggestion is that because you provide that sophisticated treatment, that you are authorized to perform those acts, you would be able to evolve into a profession which would be probably able to fill the gap which will be created when a cap comes into play in 1993 as suggested by this legislation for podiatrists. Correct?

Mr Springer: I think that like any other profession, there is room for evolution. The original ministry position, I believe, felt that there was not really a gap in existence—above the level of scope of chiropractic, that is—but that there was a lack of practitioners present.

Our presentation is not based on the contention that we want to evolve into that scope, but simply that to provide the present scope as listed in authorized acts we would have to be able to communicate this information to the patients.

Mr Cordiano: I understand that. Perhaps I could direct my question to the ministry.

The Chair: I have a question from Mr Wilson first and there will be some time with the second presenter who will be discussing this.

Mr J. Wilson: I appreciate the answer to Mr Cordiano's question, because it is a good one. As I understand it, you are currently communicating your assessment to your patients.

Mr Springer: We are.

Mr J. Wilson: Do you know why you are being asked to restrict that function now?

Mr Springer: I would have difficulty giving a full answer to that. My understanding is that there is an impact on other professions, and that has been a concern. Our response to that is that many of the professions that have

been presenting or will be presenting on this issue may not be primary care. We can assume, if they are referred by a physician to that particular profession, that communication of that information has been passed on.

I think it is an issue of professional pride as well for many people. Here we feel there is a very practical and real problem in restricting our present practice.

Mr Cordiano: To the ministry, then, I would simply put this: Will there, in your opinion, be a gap created between the two professions at the time we are phasing out podiatrists? There is not really anyone who is going to be filling that void other than physicians. Is that what is envisaged by the ministry to take place?

Mr Wessenger: I will have ministry staff reply to that one.

Ms Bohnen: Specifically in terms of bone surgery?

Mr Cordiano: That is what podiatrists are essentially practising in Ontario. That is the scope of their practice, if I understood correctly.

Ms Bohnen: Podiatrists are not currently permitted by law to perform bone surgery. However, the review recognized that there would be demand for that service and evidence that podiatrists could competently perform limited bone surgery, surgery that is in the bones of the toes and the forefoot, and so concluded that they should be permitted by law to do so.

However, coupled with that was the decision that since Ontario in 1980 had decided to opt for a chiropody model, the number of podiatrists would be capped. As to whether there will be a gap in the accessibility of service, it was anticipated that those patients who require surgery and nothing but surgery will be able to obtain that service from the existing group of podiatrists when they are not available from orthopaedic surgeons. Other patients will be managed more conservatively, using non-surgical techniques.

Mr Cordiano: I am to understand, then, that orthopaedic surgeons would perform the exact same function, or do that now, as a matter of course. What we are allowing in this legislation is for podiatrists to perform a minimal type surgery?

Ms Bohnen: "Minimal" in the sense that it is only certain parts of the foot and certain kinds of surgery.

Mr Cordiano: That is what I mean.

Ms Bohnen: Yes, that is correct. Orthopaedic surgeons, of course, also do surgery on the foot.

Mr Cordiano: What impact would that have on orthopaedic surgeons with respect to their practice at the present time? Podiatrists are not providing that service now, so orthopaedic surgeons are currently doing what is required with respect to surgery on the foot.

Ms Bohnen: You may wish to ask this of the podiatrists whom you will be hearing from shortly, but it is my understanding that in a sense they have been functioning in a kind of limbo. A number of them were performing this kind of surgery. One particular podiatrist was taken to court by the College of Physicians and Surgeons of Ontario. This highlighted the fact that the kind of bone surgery being done was not lawfully provided by podiatrists at this

time and put the board of regents in the position of having to police a prohibition which perhaps previously had not been well enforced. I think you should ask the podiatrists to what extent, prior to announcement of this new legislation, their members had nevertheless been doing surgery which under current Ontario law is restricted to physicians.

The Chair: We are going to have an opportunity this afternoon. We will be hearing from two more groups, the Ontario Society of Chiropody and also the Ontario Podiatrists Association. That should afford you an opportunity to pursue the line of questioning further.

Thank you for your presentation.

1430

ONTARIO SOCIETY OF CHIROPODISTS

The Chair: I will call now on the Ontario Society of Chiropodists. Welcome to the standing committee on social development. You have 15 minutes for your presentation. We would ask that you please leave some time for questioning from members of the committee. Please begin your presentation by introducing yourself.

Mr Kerbl: My name is David Kerbl. I am a practising chiropodist. I am also the president of the Ontario Society of Chiropodists. Our society represents 107 practising chiropodists throughout Ontario. In addition, our position on the proposed Chiropody Act, the position I am about to present, is supported by 78 chiropodists who are not members of the society, which represents about 88% of practising chiropodists. They have shown their support through letters written to the executive, copies of which I will be happy to share with you.

With me are Peter Guy, who has worked in institutional and private practice and is now clinical instructor at the Ontario chiropody program, and Olga Laland, who practises now at Victoria Hospital in London but previously practised in clinics in northern Ontario in underserved areas.

Chiropodists are foot care specialists, and the development of chiropody in Ontario is a function of government policy. I thought it would be useful if I explain for a moment how that came about.

In 1970 an Ontario government task force forecast that the foot care needs of Ontarians, particularly seniors, would increase beyond the capacity of the established medical profession and other existing health care professions, including podiatry, to meet them. The task force recommended a model oriented specifically to foot care. This thrust is consistent with trends in other jurisdictions—the US, the UK and Australia—where chiropody or podiatry flourish by filling a gap in the health care spectrum.

In 1981 a decision was made by the government in power that Ontario would accommodate the accelerating demand for foot care through the so-called UK chiropody model. This meant that a chiropody school was set up in Ontario, with the clinical parts of the curriculum being delivered at Toronto General Hospital and the didactic portions being delivered at George Brown College and increasingly at what is now called the Michener Institute. While awaiting graduation of Ontario-trained chiropodists to meet the demand, UK-trained chiropodists were imported to fill the gap.

Chiropody care is delivered through institutions such as hospitals and clinics. I should emphasize, because it is important background for what I am going to say later on, that an increasing number of chiropodists practise in community-based clinics and provide chiropody services to nursing homes where there is little or no medical supervision over the treatment the chiropodist provides. I, for example, practise in Ottawa in a group practice with two podiatrists.

What distinguishes chiropody—and podiatry, by the way—from other modes of foot care delivery is that our treatment modalities focus on the foot, and the approach to foot care revolves around the presumption that improper foot function, or “mechanics,” is the root of many foot problems. When confronted with a foot ailment, we address function as well as the actual symptoms. We believe this is what makes chiropody as a discipline a highly successful model.

An unfortunate side-effect of the way in which chiropody has been developed in Ontario is that the interests of chiropody and podiatry have been placed in conflict. Many in our profession, the Ministry of Health and our regulatory board see the continued existence of podiatry as a threat to our profession.

We in the OSC know that chiropody alone, at least in its current configuration, cannot meet the demand for quality foot care in Ontario. With current demographic and other trends, in particular what is known as the greying of Ontario, this situation will only get worse. However, we also know that as long as US-trained podiatrists are allowed to enter and practise in Ontario, chiropody will be stultified. It will never be able to grow and develop, as chiropody has elsewhere, in response to the legitimate and actual health care demands.

It is unfortunate that the interests of one health care profession have been juxtaposed against another, especially when today, demand for quality, professional, full-scope foot care far outstrips supply. But this is a function of a public policy decision made by a government over 10 years ago and confirmed by every subsequent government.

What those professionals whom I represent want, therefore, is a recognition by policymakers that chiropody must be allowed to evolve and grow in order to satisfy the foot care requirements of Ontarians. This was what the Health Professions Legislation Review process was all about: establishing, on one hand, an effective regulatory framework, while on the other hand making the framework flexible enough to respond and adapt to the legitimate and natural evolution of each profession. That evolution occurs because of constant developments in training and procedures and in response to patient demand.

Chiropody has benefited greatly in Ontario by being a creature of government. In crude terms, were it not for a government decision made a decade ago, the chiropody model would not exist in Ontario. The burden of foot care would be delivered by podiatry—the profession chiropody has been designed to supplant—and by other health care professionals.

Being a creature of government also has its disadvantages, the major one being the extent to which government

fiscal and policy objectives, rather than patient demand, dictate the evolution of our profession. We recognize that fiscal constraints impact to some degree on every health care professional group. In our case, fiscal constraints have meant that insufficient resources are available to many hospitals and institutions for chiropodists to practise full-scope chiropody. While our training has generally evolved to keep pace with chiropody elsewhere, particularly in the UK, public policy constraints have kept us from practising full-scope chiropody as practised in most other jurisdictions. In practical terms, our scope of practice for chiropody—and I am talking about what most of us do in institutions, as opposed to what we are trained or legally qualified to do—now lags behind the UK model we were supposed to emulate.

I must convey to you the deep sense of frustration many chiropodists feel in being unable, because of policy constraints, to deliver the type of foot care we have been trained to provide. We have in our profession a revolution of rising expectations that are not being met. This unmet revolution of rising expectations has caused a significant decline in the number of chiropody students enrolling in, or graduating from, the chiropody program. It has caused a small number of chiropodists to move into private clinics on a full- or part-time basis. A few chiropodists have left the profession; a few have gone to the US to train as podiatrists and hope to return to practise as podiatrists in the “podiatric scope” defined by the proposed legislation.

We would like, however, to thank the government and previous governments for bringing forward the Regulated Health Professions Act and the proposed Chiropody Act. Madam Chairman, if I might, I would like to acknowledge in particular the role you played as Minister of Health and the role you continue to play. The proposed legislation will remove many anomalies and some uncertainties relating to our profession and will begin to bring our scope of practice up to speed with our training, existing technology, and patient and practitioner expectations. This brings me to two specific issues I would like to address.

First, while our podiatry colleagues have the right to diagnose under the proposed Chiropody Act, chiropodists do not. We feel this is an unwarranted anomaly for four reasons:

1. Under the existing Chiropody Act, we have to date exercised the right to diagnose. To the best of my knowledge, there have been no issues or problems raised as a consequence of chiropodists exercising that statutory power, and I see no reason for it to be removed. Our regulatory board is of the same view, as are our podiatric colleagues.

2. In our clinical and didactic training, we are trained to diagnose. We can document and explain this further if you wish. Perhaps this is something Peter Guy, who teaches at the school, can respond to.

3. Without the power to diagnose, chiropodists cannot be primary contact practitioners. The practice of chiropody will be restricted to institutions, under the supervision of a medical practitioner. Such a restriction means that chiropody can never become a decentralized, community-based system in response either to patient demand or to the legitimate aspirations of chiropodists.

It also means that practitioners such as Olga, who practised for a time in an outlying area and spent most of her time outside the hospital setting, will not be able to deliver the service they now provide. Without the ability to diagnose, chiropody will be restricted, as a practical matter, to large institutions in the larger urban centres.

4. Without the ability to diagnose, our patients cannot make an informed consent to the treatment being offered by a chiropodist.

The other issue I would like to raise relates to the so-called podiatric cap, the provision whereby no podiatrist may be licensed in Ontario after July 1993. For the reasons I have set out in my introductory remarks, I want to make it clear that the Ontario Society of Chiropodists does not support the podiatric cap. It will impose a glass ceiling on our profession, an arbitrary restriction on the natural evolution of chiropody.

The professionals I represent expect that some day Ontario-trained chiropodists will be able to perform the licensed acts now limited to podiatrists under the proposed Chiropody Act. Without that potential, our profession will stultify and grow stagnant. I have already mentioned that chiropody in other countries is surpassing the Ontario model. In the UK, for example, on which our program is supposed to be modelled, chiropodists are being trained in post-graduate courses to perform bone surgery, and chiropodists routinely perform bone surgery in some National Health Service areas. In Ontario, bone surgery is reserved for podiatrists in the proposed act. As written, Ontario chiropodists will never be allowed to perform bone surgery.

I emphasize the point that the podiatry cap not only limits podiatrists; it also limits chiropodists. For that reason we oppose the cap and would support any amendment that allows chiropodists, some day and with the requisite training and in response to a demonstrated need, to perform the licensed acts now reserved for podiatrists.

Our solution is simple. The wording of subsection 3(2) need only be amended to apply to US or any other foreign-trained graduates of podiatric medicine, leaving it open to qualified Ontario- or Canadian-trained chiropodists to practise in the so-called podiatric scope. This will accommodate the revolution of rising expectations that I mentioned earlier and will, ultimately, be in the best interests of the public.

That concludes my remarks, and I will be happy to respond to questions.

Mr Owens: Thank you for your presentation, Mr Kerbl. Looking at the act under section 4, which to us is the chiropodists, and then looking at the section that addresses podiatrists, can you tell me why you are allowed to do an assessment and then treatment but not to tell me why you are doing what you are doing to me? Is there a rationale? Am I missing something in this language?

Mr Kerbl: This is our concern as well, in that we are currently communicating these conclusions to our patients. The current "assessment" versus "diagnosis" wording is very confusing. To our understanding, we require the ability to communicate this conclusion to our patients in order to

continue to treat patients the way we have over the last eight or so years since the program was developed.

Mr Owens: Madam Chair, can I put this question on the list of supplementary questions that we will speak to the ministry about?

The Chair: Yes.

Mr Cordiano: I asked the question in the previous set of presentations, and I think you have answered most of it for me in your brief, with respect to where you would like to see chiropodists evolve into a practice that would include, some day, the act of surgery being performed by your profession, I suppose. I think the question that I asked of the ministry earlier was, would the set of circumstances we are going to be imposing with the new act not create something of a gap down the road when, at some point, all of the podiatrists, by natural forces or otherwise, are no longer with us? What would happen to that niche in the health care market? If it is not going to be served by you, it would be served by, presumably, orthopaedic surgeons. How would you respond to that?

Mr Kerbl: I totally agree, because there is a difference currently between—in the new act—what chiropodists and podiatrists would be willing to do. In fact, podiatry is phased out; there will be a segment that will no longer be delivered. Presumably that could be delivered by orthopaedic surgeons, and my response is that there is no reason they could not be providing that at the moment.

Mr Cordiano: And they do not? I do not know; I am asking. Anybody can answer that.

Mr Kerbl: I cannot speak on behalf of orthopaedic surgeons, but if those services were being provided, then there would be no reason for podiatrists at the moment to be providing them. We know that chiropody and podiatry exist because there is a lack in other professions and we do fill a niche.

The Chair: Thank you very much for your presentation.

1450

ONTARIO PODIATRY ASSOCIATION

The Chair: I call now on the Ontario Podiatry Association. Welcome to the standing committee on social development. Would you begin by introducing yourselves. You have 20 minutes for your presentation, and we would ask that you leave some time at the end for questions from committee members.

Mr Zamojc: Thank you. My name is Tony Zamojc. I am a doctor of podiatric medicine and I am the president of the Ontario Podiatry Association. With me is Neil Koven, the vice-president of the association. Neil is a doctor of podiatric medicine as well; he practises in Mississauga.

The Ontario Podiatry Association represents the majority of podiatrists in Ontario and is part of the Canadian Podiatry Association. In Ontario, podiatrists are licensed and regulated by the Board of Regents of Chiropody under the Chiropody Act of 1944.

Since there is no podiatry school in Canada, podiatrists earn their doctorate in podiatric medicine after a four-year program in one of the seven US colleges of podiatric

medicine. Entry to any of these colleges requires an undergraduate science degree. All applicants must also take the Medical College Admissions Test, also known as MCAT, and competition for entry is very intense. After graduation and before being licensed, many podiatrists serve a hospital internship or residency, and this can range between one and four years.

Before moving to the specifics of the proposed legislation, I want to preface my remarks by stating that the proposed Chiropody Act is supported by my membership. Although both podiatry and chiropody are dedicated to foot care, the bill recognizes the distinctions between the two professions, which spring essentially from the differences in our current levels of training.

The Ontario Podiatry Association views chiropody and podiatry as complementary professions, sharing the same health care sector but focusing on different parts of the spectrum by virtue of our respective training, scopes of practice and delivery modes. For example, the unique and enhanced training associated with podiatry—generally, four years of post-graduate education for podiatry as opposed to three years of post-secondary training for chiropody—means that certain procedures are more appropriately attended to by one of the professions as opposed to the other. I point to section 5 of the proposed act, which draws a clear distinction between podiatric and chiropody scopes of practice. Under section 5, podiatrists are granted the authority to, first, diagnose, and second, to perform bone surgery.

I can tell the committee that the podiatric profession is pleased that the proposed act provides the legislative confirmation of a podiatric scope of practice commensurate with our training, abilities and patient demand. For that reason alone podiatrists support this bill, and we acknowledge, with thanks, the role that the current and previous ministers of health—in particular you, Madam Chair—have played.

Unfortunately, I cannot restrict myself to simply highlighting the benefits of the proposed legislation. I must also address, in the time allotted, our outstanding concerns relating to two issues.

The first relates to a mistaken perception that the interests of chiropody and podiatry are at odds or in conflict with each other; that somehow the development of foot care in Ontario has been a zero-sum game: a gain by one profession was a loss to the other. As a result, one might conclude that podiatrists would be opposed to chiropodists having the diagnosis function. I would like to state unequivocally that the podiatry profession has no objection to the diagnosis function being accorded to chiropodists. By the diagnosis function, I mean the power to communicate a conclusion. In fact, it would be logical in our view that since chiropodists are to perform surgical procedures, they must be allowed to diagnose. Since we are not involved in any way in the chiropody training program, we have no basis on which to judge whether chiropodists are, indeed, trained to diagnose. The board of regents, however, is, and we note that the board supports authorizing chiropodists to diagnose.

In short, if the legislation is amended to allow chiropodists to diagnose as one of their licensed acts, you will get no argument from podiatry.

Our second and only other concern deals exclusively with podiatry. The Ontario Podiatry Association regrets that the proposed act would legislatively implement a plan on behalf of the ministry to eventually consolidate foot care in this province under one profession: chiropody. The ministry's intention is accomplished by establishing July 1993 as the cutoff point, after which no new podiatrists can be licensed to practise in Ontario.

We find this regrettable and inconsistent. On the one hand, the ministry and act have recognized the unique training and role that podiatry plays in foot care. On the other, however, it is prohibiting the entire foot care profession from evolving and growing in response to patient demand and natural professional evolution.

There are two subsidiary issues here. First, the understanding we had with the Schwartz committee and the ministry was that the effective date of the cap would be three years after the date on which the legislation was tabled. That, then, is July 1994. By moving the date to 1994, all Ontario residents currently in podiatry programs in the United States would have the opportunity to return to practise in Ontario. We strongly urge the committee to make this very simple and valid amendment in the spirit of our original agreement with those responsible for the Health Professions Legislation Review.

The second concern is more substantive. Although frankly we do not agree with the rationale, we understand the public policy reasons for putting a cap on US-trained podiatrists practising in Ontario. What we do not understand is why any government would want to prohibit Ontario-trained or even Canadian-trained podiatrists from practising in Ontario at some date in the future.

The podiatry scope represents the natural evolution of the chiropody profession. We can document a persistent and growing demand for podiatric services. With the greying of Ontario, that demand will increase. As the number of podiatrists declines, who will fill that need? Experience shows that orthopaedic surgeons and general medical practitioners cannot.

The logical and natural successors to podiatrists in Ontario are chiropodists, trained to perform what is now called the podiatric scope of practice. The Schwartz committee recognized this, we recognize it and our colleagues in the Ontario Society of Chiropodists look forward to it.

The podiatric cap militates against the natural evolution of the chiropody profession and will leave Ontario, some day, without enough qualified practitioners to respond to patient demand. We propose keeping to the podiatric cap—extended, of course, to 1994—but applying only to foreign-trained doctors of podiatric medicine. This proposal is in harmony with the intent of the legislation, that being to create a flexible framework that accommodates the natural and legitimate evolution of the regulated health care professions. To retain the cap is to place an arbitrary and artificial cap on chiropody and engage in an exercise of swimming against the tide.

That concludes my remarks. I think you will agree that our proposals are in the public interest, and we would be happy to entertain questions at this time.

Mr J. Wilson: I am trying to get a better understanding of the cap on podiatrists in 1993. Is it your understanding that it is the ministry's intention to expand the scope of practice of chiropodists at that time? We are not just putting podiatrists out of business; we are, I understand, putting them into one profession called chiropody.

Mr Zamojc: Yes, the legislation for the act is in basically a two-tiered system. One will include the additional portion as bone surgery for podiatrists in the province, and then the soft-tissue surgical procedures, ingrown toenails, warts and things like that, as well as injections and prescriptions, are extended to everybody. So there is that additional section that makes the podiatric portion of the act slightly different.

Mr J. Wilson: I understand that, but what about after July 1993?

Mr Zamojc: In July 1993—or, what we are hoping for, 1994—basically any podiatrists who graduate in the United States, regardless of whether they are Canadian—for example, practising out in British Columbia—if they wish to come back to Ontario after that date, would be allowed to practise under only the chiropody side of the profession. They would not come in under the podiatric scope after 1993 or 1994. That is the end of that podiatric scope for anybody coming in at that time.

Mr J. Wilson: So after July 1993 or 1994, chiropodists are limited to the scope of practice that we are being asked to pass. If this passes, podiatrists would then be limited to the same scope and neither will be doing bone surgery, which podiatrists are still doing.

Mr Zamojc: But American-trained podiatrists would not be allowed into Ontario to practise under the podiatric scope. Actually, there is one error in that.

Mr J. Wilson: I am just trying to get a feel for the state of affairs after July 1993.

Mr Zamojc: There is one error in that. The practising podiatrists in British Columbia, if they are licensed before the 1994 date, can enter Ontario and practise at the full podiatric scope.

The Chair: For clarification, I have had a request from the parliamentary assistant to clarify. Is that acceptable? It will probably use up your remaining time.

Mr Wessenger: I would like the ministry to clarify this point.

Ms Bohnen: The scope of practice of podiatry will not narrow on that date in 1993. What will happen is that no further additional podiatric registrants will become registered with the college, so that there will be a limitation on the group of practitioners entitled to practise the expanded scope. That is the significance of that date.

Mr J. Wilson: What happens eventually when your podiatrists die off? Who does bone surgery?

Ms Bohnen: There are two answers to that. One answer is that orthopaedic surgeons do the bone surgery, which is what they do today. The second answer is that, should there be a need in the future identified for further practitioners of bone surgery and, second, should the educational program for chiropodists in this country be expanded to

teach bone surgery, then at that point I think we would expect to see a proposal for an amendment to the act which would be circulated and placed before the advisory council.

Mr Waters: What kind of cost difference are you talking on these types of things? It is to serve the public. You are saying that as podiatrists die out, I guess, it will all be picked up by someone else. Is that an increased cost?

Mr Burrows: I would like to suggest that question be best directed to the members of the profession in terms of comparative incomes and so forth. However, I would like to point out that the chiropody model, as a matter of ministry policy, has existed since the early 1980s and has not changed under three successive governments. The need, in the ministry's opinion, has been for a much broader access but limited scope of practice because the need in such groups as senior citizens for some sort of low-risk but preventive and supplementary care is what has led to the formation of that policy.

But, as Linda pointed out, should circumstances change in the future, the notion under this legislation is that it is living legislation and should that need be there and the need for additional practitioners present itself, there is a fairly ready way of amending things so that could occur. But that would require a policy change and a decision at that time.

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Mr Cordiano: So in that sense, the ministry has virtually identified a lack of need for this type of specialized foot care. At some point in the future when podiatrists are no longer with us, that void would naturally be filled by orthopaedic surgeons who are currently providing the same surgical treatment.

Ms Bohnen: Yes. In respect of surgical treatment in the forefoot, yes, what you said is quite correct.

Mr Cordiano: So orthopaedic surgeons are, as a matter of course, doing this regularly at the present time?

Ms Bohnen: I believe so.

Mr Cordiano: I should ask the former minister.

Mr Hope: Just for clarity, you are saying "foreign-trained" and they are saying "US- or foreign-trained." I would like to know what the difference is.

Mr Zamojc: We are basically stating that if there is a podiatrist produced in this country and working in British Columbia, because British Columbia also has a podiatry group, and Quebec is in the process of producing a podiatrist model with additional training out of New York colleges of podiatric medicine—the eventual evolution of a school of podiatric medicine in this country, which is conceivable either in Quebec or in British Columbia in the future—we want to make sure there is still an opening for those trained people to enter Ontario, rather than limiting it to just the American-trained. We can see the point of the Americans, but when it is our own citizens of anywhere in the country who do not have that free movement to practise, we basically say "foreign-trained." That would be anybody outside of Canada.

Mr Jackson: I am trying to get a sense of the concepts of deinstitutionalization and access here. I am getting nervous

about the phase-out of podiatrists coupled with the loss of diagnostic abilities for chiropractors. Essentially, the outcome of that would be the need for more physicians to examine foot ailments and do referrals to orthopaedic surgeons. I have had bad experiences with orthopaedic surgeons and really good ones with podiatrists and chiropractors; it has probably saved OHIP thousands of dollars. I am now nervous that both groups have referenced institutional settings and yet the model for care for the elderly in this province will be in a deinstitutionalized vein. I am really nervous about this because it will be more costly. It might be a Rolls-Royce health care system that we can fast-track them all to orthopaedic surgeons, but by the same token, there is a whole lot of preventive areas involved with foot care that might be limited here. Would you like to comment on my concern?

Mr Zamojc: One problem in the legislation, especially with the cutoff date being so finite, is that there is no room for the evolution chiropractors have mentioned, as well as us, into what Ontario can have as a full scope of chiropractic. There is one, then we die off and then there is something else with this space in between. There is no evolving process going on with an interrelationship between the two. That is a weakness I see in the thing as well. That is possibly one of the reasons for the attempt at making the 1994 date, which is still a finite date, but allows all the Canadians down in American schools to come back, as well as providing the other side of it to provide Canadian-trained podiatrists. There will be more of bridging that gap between the two, and the free movement of that level country-wide will provide that. In that respect, I feel this is going to help that gap we referred to earlier as well. That is really my only comment.

The one thing I would like to note is with regard to the orthopaedic surgeons and us doing surgery or foot care as well, there are differences and similarities between the two, versus ambulatory foot surgery and the use of orthopaedic supports and devices and that kind of thing. There is a sort of continuum with the orthopaedic surgeons as well, so I feel we are all going towards the same goal providing a service at a multistaged sort of level.

The Chair: Mr Owens, I have a note that you had a question on this matter of the ministry. Did you want to ask the parliamentary assistant at this time to get it on the record, or has it been answered in the discussions?

Mr Owens: I think it has been answered.

The Chair: A question from Mr Jackson to the parliamentary assistant to be answered at a later time?

Mr Jackson: Yes, that has to do with long-term care reform. I would like to know to what extent foot care matters are being considered in that discussion paper as it relates to the issues I am concerned about with respect to access and deinstitutionalization. I would like to know to what extent there is a dialogue or thinking going on between this piece of legislation and the long-term care agenda.

The Chair: Thank you very much for your presentation. We appreciate hearing from you.

1510

VISION COUNCIL OF CANADA

The Chair: The next presenters, Vision Council of Canada, please come forward. We ask that you begin your presentation by introducing yourselves. You have 20 minutes, and please leave some time at the end for questions from committee members.

Mr McArthur: Madam Chair, members of the committee, good afternoon. My name is John McArthur. I am pleased to be here to present this brief on Bill 59, An Act respecting the regulation of the Profession of Opticianry, in my capacity as president of the Vision Council of Canada. I am joined today by Ross King, who is a member of the board of the vision council.

First, I would like to give you a bit of background about the Vision Council of Canada. The VCC is a nationwide, non-profit organization which was incorporated in early 1989. In Ontario its members represent a significant number of retail optical outlets. VCC members and supporters employ over 1,000 people, including more than 25% of the province's licensed opticians. Our mandate is to ensure that the highest quality of eye care products and services are available to the public at a reasonable cost.

The VCC fully supports the goals of this package of legislation. We believe that the system of patchwork acts which currently regulates the various professions has often led to inconsistent policies and has made it extremely difficult to address emerging problems. The RHPA and the 21 acts governing the individual professions will ensure that the public will be accorded the same rights and remedies regardless of the professional providing the treatment or advice.

As it relates to the vision council and our presentation before your committee today, we believe the legislation governing the profession of opticianry falls short in one very important and fundamental respect: the absence of a precise definition of the act of dispensing eye wear, both in the opticianry scope of practice and the authorized act.

The vision council believes that the lack of such a definition will or could result in unnecessary and costly commercial restrictions on the practice of opticianry. The Vision Council of Canada believes the following definition of "dispensing" should be added to the Opticianry Act. I will quote:

"The final verification of an ophthalmic appliance for conformity and suitability to a prescription issued by a prescriber and the final fitting and delivery of the ophthalmic appliance to the designated person."

For purposes of consistency, we would respectfully suggest that this definition also be included in Bill 60, An Act respecting the regulation of the Profession of Optometry. We believe this definition, in conjunction with the controlled act, appropriately identifies and controls the limited risk involved in the dispensing of eye wear. At the same time it preserves the role of the optician in this process.

Without a definition of dispensing, there is no certainty as to what the government intends to be a controlled act limited to the profession of opticianry. Conversely, there is no certainty about what is permitted to be done by their

unlicensed and unregulated assistants or staff. At the same time, an overly broad definition of dispensing, such as the one under which opticians are currently regulated, neither increases accountability, and thereby the quality of our product, nor improves access. In fact, it potentially impedes access. Without a specific definition of dispensing or with one which is too broad, an optician could be required to be present throughout the entire process of obtaining a pair of eyeglasses.

What does this mean in practical terms? It means that in the majority of optical retail stores, the optician must shut down his store to go to lunch. It means that in the existing legislative framework and potentially under the legislation we are discussing, should his assistant help a client choose a frame, the optician can be charged by the Board of Ophthalmic Dispensers and/or its successor college with a violation of the act. It means that access to quality eye care is more difficult and more expensive. This is also the result of the broad definition of dispensing included in the legislation currently regulating opticianry.

We believe that in introducing the RHPA and its companion pieces of legislation, the government made a conscious decision to depart from the present system. We hope that it will carry its decision through and include a focused definition of dispensing in Bill 59.

At this point it is important to note that what we are suggesting would in no way create a greater risk of harm for the public. In a letter to the Board of Ophthalmic Dispensers, Dr B. J. MacInnis, chairman, professional affairs, section on ophthalmology of the Ontario Medical Association, wrote as follows, "An incorrectly dispensed prescription for a visually mature adult may blur vision, cause diplopia"—which in lay terms means double vision—"induce an heterophoria"—meaning causes problems with regard to focusing on an object—"cause asthenopia"—which is eyestrain—"or induce headaches." Most significantly, Dr MacInnis added, "No permanent harm ensues."

The section on ophthalmology does believe that contact lenses have a very definite potential for permanent harm and should be dispensed only by regulated professionals. We agree. They state as well that an incorrectly dispensed prescription for a child under the age of visual maturity, which 99% of the time is under nine years old, carries the potential for harm in the form of amblyopia, which is a dimness of sight. Again we would agree.

The vision council believes that these two potential areas of harm should be specifically controlled, either directly in the legislation or in ensuing regulations. We wish, however, to emphasize again the limited risk of harm overall that is associated with the dispensing of eyeglasses.

As you deliberate this issue, we hope that you will consider the following: A staff study by a US government agency looking at issues similar to those reviewed in this process found that, "commercial practice restrictions...actually decrease the quality of care in the market by decreasing the frequency with which consumers obtain eye care." In fact, there are many North American jurisdictions which do not regulate opticians to the degree Ontario does, without any adverse consequences to the public.

In her comments during second reading of the legislation, former Health minister Evelyn Gigantes commented, "It is important for us to acknowledge that there is such a thing as overmedicalization." While Ms Gigantes was not directly referring to opticianry, we believe that the concept is applicable here. We are asking you not to overmedicalize the provision of eyeglasses.

Again, we support the intent and the direction of this legislation and heartily endorse one of its primary objectives, the protection of the public from risk of harm in health care. We ask, however, that you not use it for a purpose for which it was not intended. We ask that you not use it to protect the profession's self-interest. We do ask that you use it to protect the public and to ensure a high-quality, cost-effective health care. Thank you very much. We would welcome your questions.

Mr J. Wilson: Thank you for the presentation. I have yet today to hear any reason why your proposal concerning the definition of dispensing is not workable, but if we did not include it in the act as an amendment, just on the employment side, which is certainly not addressed—you have, I would imagine, among your members and in their shops a great many technicians—do you have any idea how many people might be affected? You would still need them to do some of the work, but if they are not actually doing the dispensing—

Mr McArthur: You are talking about non-opticians?

Mr J. Wilson: Non-opticians.

Mr McArthur: I actually could not give you a number of individuals who would be affected. It would be a considerable number of that thousand that I referred to with respect to our specific membership. It would be significantly larger than that, considering all of the optical retail community.

Mr J. Wilson: I ask because I have a couple of good friends who I think work for you.

Mr McArthur: I am sure their jobs are secure. I think the absence of a definition, first, leaves in great question what exactly is the role of an optician and what can or cannot someone who is not an optician do. There are many today working with that uncertainty over their heads and they do not know what in fact they are allowed to do and not to do. That is why we believe that specifically defining what the act of dispensing is, and we believe, as we have suggested, that the definition ought to be restricted to those areas where there truly is a risk of harm, will protect the public and provide the most cost-effective and accessible health care.

Mr J. Wilson: Would your amendment need another sentence added to do exactly that, restrict it to those areas where there is indeed severe risk of harm? You give a suggested definition on page 2, and then you do mention the two exceptions of children and contact lenses.

Mr McArthur: I think in any event both of those conditions would be protected by the definition that we have proposed, in that nobody would be leaving an optical outlet without having had an optician check the ophthalmic appliance and verifying that it is correct according to the

prescription and that it has been fitted correctly to the patient's or customer's face or eyes.

Mr J. Wilson: And the liability would still be with the optician, clearly?

Mr McArthur: Absolutely.

Mr Owens: If we were to agree to the proposal of the amendment, and you are suggesting this would lead to increased consumer protection, would it also help in terms of the cost of glasses and prescription lenses and things like that to some extent? How would it do that?

Mr McArthur: The fact is that currently, with the uncertainty that revolves around what someone who is not an optician can do, it can lead to someone who has been trained for a two- to four-year period of time doing a task you do not require that amount of training to do.

A for instance is deciding on what set of frames you want, forgetting about the lenses that go inside them. That is to a great extent a fashion issue. It is also to a certain extent a comfort and fit issue. You do not require to be educated for that period of time.

Having been educated, that accreditation carries with it a salary that is higher than would otherwise be the case, without necessarily providing any increased service to the public, and certainly not eliminating any degree of risk upon them.

Mr J. Wilson: Just as a follow-up, we will have the OMA speaking before the committee at some point. Have you had discussions with them to see if they are comfortable with your definition at this point?

Mr McArthur: We have not been able to meet with the OMA. We have requested that meeting. We were not able to arrange it.

The Chair: Thank you very much for your presentation. We appreciate the opportunity to hear your point of view.

Mr McArthur: We appreciate it as well. Thank you.

1520

BOARD OF OPHTHALMIC DISPENSERS

The Chair: The next presenters, the Board of Ophthalmic Dispensers, please come forward. Welcome to the standing committee on social development. We would ask that you begin by introducing yourselves. You have 20 minutes for your presentation and we ask that you leave some time for questions from members of the committee at the conclusion.

Mr Buckstein: My name is Murray Buckstein. I am a public member on the Board of Ophthalmic Dispensers, and with me is Mrs Barbara Skinner, who is a professional member on the Board of Ophthalmic Dispensers.

The Board of Ophthalmic Dispensers, established by the Ophthalmic Dispensers Act of 1961 and consolidated regulations under the act, is charged with the responsibility of administering and enforcing the act and its regulations. As the governing body for the profession of opticianry, the board ensures that citizens of Ontario receive the highest standards of care and service in all areas of ophthalmic dispensing, provided by opticians who under the act must be registered with and deemed competent by the board in

order to practise in this province. Currently in Ontario student opticians must undergo community college training. The professional dispensing service they provide, once registered by the board, involves the design and provision of eyeglasses, contact lenses and devices for subnormal vision, based on the interpretation of a prescription provided by an optometrist or a physician.

Under the proposed Regulated Health Professions Act, 1991, and the Opticianry Act, 1991, the board will continue to function as the College of Opticians, charged with the responsibility of regulating the profession of opticianry and ensuring that the public interest remains paramount in the provision of all professional ophthalmic dispensing services. Both acts also specify certain procedures and powers with which the college and the courts may regulate those services, and they establish very specific penalties for breaches of various provisions.

In the view of the board, however, there is a very serious omission in the proposed act, the failure to provide, as does the present Ophthalmic Dispensers Act, a specific, clear definition of the word "dispensing," the very activity in which professional opticians engage. Accordingly, the Board of Ophthalmic Dispensers respectfully submits this concern to the committee and hopes the committee will take it into consideration when making recommendations prior to third reading of the proposed acts.

It is our firm belief that the inclusion of a definition of dispensing is mandatory. Without one, it will be left to the interpretation of individual opticians and/or the various corporations which employ a very large percentage of those practising in this province, some of which may, for economic self-interest or other reasons, define dispensing in terms other than those understood by the college to be in the public interest. This will make a determination of illegal and unprofessional activity virtually impossible in cases in which charges involve the dispensing of ophthalmic services and products, necessitating, in turn, the time, expense and involvement of the courts, all of which could be avoided by defining this most important term in the proposed Opticianry Act, that is, Bill 59.

After very careful consideration of the intent of the Regulated Health Professions Act and the Opticianry Act and ever-mindful of the college's obligation to protect the interests of the public, the Board of Ophthalmic Dispensers, in consultation with the two professional associations to which opticians in Ontario belong, that is, the Ontario Association of Dispensing Opticians and the Ontario Contact Lens Association, has established a definition which ensures the provision of professional services by trained, qualified persons only and which protects the public interest to the fullest. This addition, which we propose to be included in section 1 of Bill 59, that is, the section relating to definitions, would define the words "to dispense," which now appear in section 4, line 5, as follows,

"'To dispense' will mean: (a) interpreting a prescription for; (b) evaluating or advising a person in respect of; or (c) preparing, providing, verifying, adapting, fitting or duplicating a device for subnormal vision, a contact lens or eyeglasses."

The unique environment of optical dispensing necessarily involves considerable judgement and interpretation on the part of the optician in order to formulate the best vision aid for his or her patient, based not only on the prescription presented, but also on the personal needs and location of that patient. Most ophthalmic dispensing takes place in what is generally considered to be a retail environment. It is not performed under the same scrutiny or constraint as provided by hospitals, clinics, or other institutions regulated by the Public Hospitals Act, or by pharmaceutical dispensaries regulated by the Pharmacy Act.

Because of this, the board is of the unanimous opinion, expressed by public and professional members alike, that standards of quality already established and enforced to protect the people of Ontario can only be maintained by including a clear, precise definition of dispensing in the Opticianry Act. With the definition we are recommending, all regulated functions of professional dispensing will be clearly defined and easily understood both by practitioners and the public whom they serve. It provides the clarity and detail that is required to ensure the continuation of a professional dispensing service and will therefore be in the best interests of the public.

To assist the standing committee in understanding the functions of a professional optician, we have attached a chart on the following page to graphically illustrate those functions. I might add that you will note, in glancing at that chart, that some of the functions that may have been previously described to you as being regulated, such as vision counselling and selection of frames, etc., are not currently regulated, nor are they proposed to be regulated by the board. That, Madam Chairman, is our formal presentation and we would answer any questions that the committee may wish to ask.

Mr Grandmaitre: I would like to ask the ministry to define the word "dispense." Do they agree with what is before us? What were their initial thoughts on the word "dispense"?

Mr Wessinger: I will ask the ministry staff to indicate what the word means.

Ms Bohnen: I do not think I can define the word for you at this moment, but I can tell you that the Health Professions Legislation Review came to the conclusion that it was best not to define the word in the statute. The word "dispense" has a number of meanings in health professions acts. It has a meaning in the context of pharmacies dispensing drugs. It has a meaning in the context of dispensing personal hearing aids. The review is of the opinion that a statutory definition would not be helpful, that fundamentally the standards of practice required of a regulated health professional were the key to ensuring the public receives an adequate quality of professional service and that within each industry a definition comes to be worked out over time as business is conducted. I guess the key point is that the regulated professional is responsible for adhering to the standards of practice of his or her profession.

Mrs Skinner: If I could just help in that a little bit. Sometimes the word "dispense" as applicable in our industry is very difficult for the consumer to understand. Many of

you here today are wearing eyeglasses. We basically agree with our predecessors here today that a definition should be in place. The only difference we are talking about, I believe, in looking at the two proposals you have before you, is that the first proposal says you may pick up your eyeglasses from an optician and have them adjusted. However, you may not see the optician up until the point of final delivery to the consumer. That is not as it has been in Ontario for the last 30 years.

What it leaves out is the interpretation of the medical prescription prior to the manufacture of the eyeglasses. This means that when you come into an optician's and you give him or her that paper with the numbers on it, those numbers are not always the numbers you get in your lenses. It is very simple and easy to understand. There is a judgement that is made by the optician prior to the manufacture of the client's eyeglasses or contact lenses. We have to use the training and experience we have on the vocation or avocation of the person. Do they want to read at 14 inches, which is on the prescription, or do they work at a computer all day, in which case that prescription will be useless for them? We have to make a judgement and that is what we are trained to do.

We are hoping this second definition, as we are proposing, would include that members of the public would see the optician prior to the manufacture of the eyeglasses so that the design could be worked out with the intent of the prescription of the medical practitioner and, at the final verification of that design, would be concluded. That is what we are hoping to do here. We are certainly not trying to restrict fashion consulting or, as we also have listed here, acts not requiring registration: the product information, which could be generic lens designs to the consumer. We are hoping, after that fashion consulting is done, that the optician would be seeing the consumer even for a short moment to make sure of decisions such as, "The lovely red frames look beautiful, Mrs Jones, but your prescription won't go into it." We want to make sure those previous decisions on fashion are going to complement the intent of the appliance and be wearable for the patient.

Mr J. Wilson: Is it possible that the Vision Council of Canada and your group could get together and bring back one definition or have you been hammering this out for 30 years?

Mrs Skinner: We have met previously to this and presented our reasons. Their feelings were that final verification was all that was necessary. It is a regressive step in Ontario. Opticians have been licensed to provide this eye care since 1961 with a definition that includes the interpretation of prescription. Without the word "interpretation" in our act, our board is assuming the public will be protected with the inclusion of interpretation under the definition of "dispensing."

Mr J. Wilson: If you end up in court, for instance, the judge is going to ask the same thing.

Mrs Skinner: Exactly. We are different from some regulated professions, where you may not take someone to court for pretending to be a doctor or doing those acts, but they do take people to court for illegal dispensing. We have a definition under the current legislation that is much lengthier than the proposed one which covers it in detail.

We have had a recent decision from the Court of Appeal for Ontario and it does hold up the present definition of "dispensing" under the Ophthalmic Dispensers Act. So without a definition in there you are right; it would be a lengthy court case, probably, with the Court of Appeal left to decide what the intent was. We are hoping that can be eliminated by including a definition in this act.

Mr J. Wilson: Where legislators are normally confronted with conflicting and not quite consistent definitions from two different parties, probably that is what the review panel found and decided not to put a definition in at all.

Mrs Skinner: I hope you give some consideration to the source of the two definitions you have before you. One is from the regulatory board, which is ourselves, setting the quality assurance standards and the standards of practice. One is from membership of corporate entities who, I agree, are employers that often have an economic interest, which we do not at the present time.

Mr J. Wilson: They are employers and they are providing a service to people. It could boil down to a question of access and efficiencies.

Mr Buckstein: I think too, Mr Wilson, having sat on the disciplinary committee for some three or four years and listened to some of the cases that have come before us, and some of the charges of unprofessional conduct, if the intent of the Regulated Health Professions Act is to ensure that the public receives public health care in all areas, it would be very difficult to do without the definition we described in the detail that we described. Again, I think they are being very realistic. There is an economic self-interest that is involved in the case of some employers, some corporations, and we see that before us when these charges are raised all the time. As the regulatory body charged with the responsibility of ensuring that the public receives professional eye care service, we feel that this definition we propose covers all the bases.

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ONTARIO ASSOCIATION OF OPTOMETRISTS

The Chair: The Ontario Association of Optometrists, we are five minutes early, but if you are prepared and ready to go we could begin now. Please come forward. We ask that you begin your presentation by introducing yourselves to the committee and leave a few minutes at the end of your presentation for questions from committee members. You have 20 minutes for your presentation.

Dr Trinaistich: I would like to introduce myself first. I am Dr Mary Trinaistich, president of the Ontario Association of Optometrists. With me are Dr Lynn Carter, chairman of our legislative committee, Dr Marvin Langer, a member of the legislative committee, and Dr Mira Acs, vice-president of the Ontario Association of Optometrists.

Members of the legislation committee of the Ontario Association of Optometrists and our board of directors thank you for this opportunity to appear before you. Our brief submission today on Bill 60, An Act respecting the regulation of the Profession of Optometry, focuses on the effects Bill 60 will have on the delivery of eye and vision care services and programs.

Let me begin our dialogue with a short description of the profession of optometry in Ontario. We are an independent, primary health care profession that has been self-regulated since the passage of the optometry act in 1919. Optometry is one of the five health professions currently regulated under the Health Disciplines Act.

We, the Ontario Association of Optometrists, incorporated in 1909, are a voluntary professional association. The regulatory and licensing body is the College of Optometrists of Ontario, which replaced the Board of Examiners in 1960. Its published standards of practice, which are continuously reviewed and updated, have been in place for more than 20 years. These standards have been upheld by the Health Services Appeal Board and the courts.

The school of optometry, in the faculty of science at the University of Waterloo, has provided since 1969 the academic and clinical training of optometrists. Upon completion of a four-year professional university program, the entry into which requires the prior successful completion of a minimum of one year of a university science program, a doctor of optometry degree is awarded.

Optometrists then are self-regulating, provincially licensed, professionally educated and clinically trained to assess, to diagnose, to treat and to prevent conditions, ie diseases, disorders and dysfunctions, of the eye and visual system. In so doing, optometrists are required to provide this care to their patients in accordance with the standards of practice published by the College of Optometrists.

Currently there are approximately 850 licensed optometrists in Ontario practising in 80% of the communities with a population of 1,500 or more. In 75% of these communities, optometrists are the only source of eye and vision care. In fact, outside of the larger urban centres optometrists are for the most part the only specialized eye care professionals available. Changes to the practice of optometry are therefore sure to have a very significant effect on the eye and vision care services in many localities. The geographical impact of these effects can be seen in attachment (a).

The two sections of Bill 60 we would like to address specifically are section 3, scope of practice statement, and section 4, authorized acts.

Scope of practice, section 3: "The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of vision and oculomotor dysfunctions of the eye."

Authorized acts, section 4: "In the course of engaging in the practice of optometry, a member is authorized, subject to the terms, conditions and limitations imposed on him or her certificate of registration, to perform the following:

"1. Communicating a conclusion identifying a vision or oculomotor dysfunction of the eye as the cause of a person's symptoms.

"2. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eyeglasses."

In an overview of impacts of Bill 60, at the outset let us state that if the intent of the legislation is that the practice of optometry in Ontario should continue as it is under part V of the Health Disciplines Act, then amendments must be

nade to sections 3 and 4 of Bill 60. We understand that in er briefing on August 6, Linda Bohnen stated that in the opinion of Alan Schwartz's team, optometry got the status quo. Respectfully, this is not so.

The considerations which we will raise with you now are not, as it may be suggested, motivated either by economic considerations or by the desire to maintain or obtain exclusivity over the area of practice. Plainly put, we are interested in being able to continue to provide the same level of health care services to our patients and, in so doing, provide them services in an efficient and cost-effective way.

In the executive summary of *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions*, Mr Schwartz described one purpose of a scope of practice statement. He wrote, "It will describe for consumers, members of the profession, employers, and the courts the proper range of the profession's scope of practice."

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With respect, we point out that the scope of practice statement and authorized acts in Bill 60 will place severe constraints on the range of services optometrists may legally provide. The current proposals will restrict the historical pattern of optometric practice. These restrictions have potentially grave consequences for the effective delivery of eye and vision care services in Ontario. These would include negative impacts on health service expenditures, limitations on access to and availability of services and the disruption of existing public health care programs.

These restrictions on or limitations to optometric practice will arise because of the omission in the scope of practice statement and in the first authorized act of conditions described as "diseases" and "disorders." Optometrists have always diagnosed, treated—including monitoring—and prevented diseases and disorders of the eye. The result of these omissions will be that patients can no longer receive the services they have come to expect from their optometrists.

All of the organized bodies of optometry in the province believe this proposed redefinition of optometry will move the practice of optometry to a more limited position than it has ever occupied in Ontario. This will severely restrict the provision of eye and vision care services.

When we first received the Health Professions Legislation Review proposals in 1989, and after consultation with our colleagues, we sought the opinion of three legal counsel on the impact these proposals would have on optometric practice. We have provided their opinions for your review in attachment (b).

Briefly, these opinions all state that the definition now before you in Bill 60, coupled with the authorized acts, will narrow the profession of optometry from its current scope of practice. They all agree that optometrists will not legally be able to continue to provide all of the services they currently provide, as they will be prohibited from communicating the diagnosis and identification of diseases and disorders of the eye and visual system to their patients.

If this happens, the OAO will be forced to advise its members that in order to maintain their professional liability coverage, they must now refer patients for whom they have previously provided care and who currently, under the Health Disciplines Act, do not require referral. Let me

take a minute now to give you two examples from my daily practice that will demonstrate just how these limitations will disrupt our services and care to our patients.

In the case of a patient with cataract, in current practice I make a diagnosis of a cataract, monitor its development, provide for changes in the patient's visual needs and consult with my patient. I would refer this patient for surgery for the cataract when it reached the stage where surgical intervention was appropriate. In future practice under Bill 60, I would have to immediately refer this patient, because I would be prohibited from communicating my diagnosis and effectively monitoring this patient.

In the case of a patient with blepharitis, in current practice I make a diagnosis of blepharitis—a disease condition of the eyelid whose appearance is red, flaky lids—in my patient and I recommend the appropriate treatment for it. If it is a severe case, I refer this patient to a medical practitioner. In future practice under Bill 60, I would have to immediately refer this patient to a medical practitioner, because I would be prohibited from communicating my diagnosis of this disease, recommending treatment and monitoring the efficacy for this patient.

Turning now to the financial consequences, we believe that unless Bill 60 is amended, the cost of eye care services will dramatically increase. The increase will arise as a result of unnecessary referrals to physicians to have optometric findings confirmed.

In 1980, Dr W. Harding le Riche authored a study documenting the eye and vision care services provided by optometrists to a representative sample of patients in Ontario. The study found that optometrists diagnosed disease for 42% of their patients and subsequently had cause to refer about 13%. Under the provision of Bill 60, the almost 30% of patients in this study who did not require referral at that stage, if at all, would now be referred, at considerable cost. For example, according to OHIP statistics, optometrists provided services to 1.7 million patients in 1988-89. Applying the results of the le Riche study, there would be over 500,000 extra referrals to other health care practitioners, at a conservatively estimated cost of over \$20 million with no benefit to the patients. It would be imprudent, we believe, to increase eye and vision care delivery costs without any expansion of services simply because of a poorly worded definition.

In addition to increasing the cost of eye and vision care delivery, these legislative proposals will ensure that many patients will suffer unnecessary delays in obtaining treatment and will have to travel outside of their communities at personal and/or public expense to receive treatment.

Optometrists are the most accessible and available eye and vision care professionals in Ontario. Optometrists practise in all Ontario counties, districts, regional municipalities and in more than 80% of Ontario's communities with a population of over 1,500. As a result, patients of optometrists have consistently reported waits of two weeks or less for appointments. If optometrists must now unnecessarily refer more than 500,000 patients yearly to ophthalmologists, it will increase the waiting time of non-emergency eye care. Where no ophthalmologists are

available locally, patients will have to travel, often at great distances and at considerable cost.

The magnitude of this potential problem is difficult to assess. However, we have identified 15 counties/districts with an estimated 1991 population of 681,000 with no ophthalmologists. These same areas have 68 full-time practising optometrists.

The Ministry of Health has an assistive devices program which provides financial assistance to visually impaired residents for the purpose of obtaining specified low-vision aids. The ADP recognizes optometrists as authorizers, with physicians, of low-vision devices. In their role as authorizers, the optometrists must provide "primary diagnosis (eg, achromatopsia) including level of functional visual disability...secondary diagnosis if any, eg, cataract, cerebral palsy." We believe that with the current legislative proposals, optometrists will be prevented from continuing to practise in the Ministry of Health's ADP.

The federal Minister of Finance amended the Income Tax Act and the disability reporting certificate for the 1988 taxation year to allow optometrists to certify severe and prolonged sight impairments. Optometrists as well as physicians must provide a "diagnosis of the disabling condition and any other associated conditions causing the marked restriction in ability to perform basic activities of daily living." Again, it appears that with the proposed legislative changes optometrists will be forced to discontinue providing this service for their patients.

The government stated, when introducing this package of legislation, that it provides for uniformity in the regulatory framework; enhancement of public protection; protection of the right of consumers to receive health services that are competently performed to suit both their needs and desires; protection of the right of health professionals to work in an equitable system that recognizes their autonomy and respects their contributions; and establishment of a system that reflects the reality of the health care system and facilitates evolution within it.

We support these intentions. Indeed, we have been willing supporters and participants in this lengthy review process. It is no secret, however, that we have been less than happy with the outcome. We do not believe that these goals have been achieved for our profession and optometric patients.

We are pleased that the Minister of Health views this as "living legislation." If the status quo had been achieved with Bill 60, we would be far more willing to adopt a wait-and-see attitude, to monitor the impact of the legislation and see what evolves. However, it has not been achieved and we cannot, indeed we must not, abdicate our professional responsibility to our patients, to our communities and, yes, to ourselves as well-trained professionals in a scientific health discipline to try to amend this legislation.

We offer the following suggestions for amendments in that spirit. We believe they are in keeping with the stated intent of this health legislation. We propose for a scope of practice statement to consider the services currently performed by optometrists, "The practice of optometry is the assessment, diagnosis, treatment and prevention of diseases, disorders and dysfunctions of the eye and visual system."

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We further request that section 4 be amended to the following:

"1. Communicating a conclusion identifying a disease, disorder or dysfunction of the eye and visual system as the cause of a person's symptoms.

"2. Performing a procedure on tissue in or below the surface of the cornea.

"3. Applying or ordering the application of a prescribed form of energy.

"4. Prescribing a drug.

"5. Prescribing or dispensing subnormal vision devices, contact lenses or eyeglasses.

"6. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

"7. Prescribing or ordering orthoptic and/or vision therapy."

In summary, the scope of practice statement in Bill 60, the Optometry Act, 1991, will substantially alter optometric practice, increase costs and reduce accessibility in the delivery of eye and vision care services in Ontario.

We are unreservedly opposed to the proposed restrictions of optometric practice that this legislation will necessitate.

We believe the Ministry of Health and members of the committee will understand that the changes to the eye and vision care system that are consequent to these legislative proposals are not in the best interest of the people of Ontario and will take the appropriate action to amend this legislation.

Thank you for this opportunity to make our concerns known to the committee. We would be pleased to make available any other information or points of clarification which you require.

Mr Owens: If we were to pass the scope of practice as is proposed currently, where would it put you in comparison to other practitioners in other jurisdictions in Canada and the United States? If we were to accept your amendments, where would you draw the line between yourselves and ophthalmologists?

Dr Trinaistich: I would like to pass that question on to Dr Carter. He will answer that.

Dr Carter: There is not another jurisdiction that we are aware of in North America that would restrict optometry as much as this proposal is going to do. We are not aware of any jurisdiction which prohibits optometrists from communicating to the patient, for example, that he has a cataract. I guess the example that needs to be elaborated is in that the United States, in those jurisdictions there has been a bit of a trend recently, in the past 10 years' time, to not only allow optometrists to continue to diagnose and discuss that diagnosis or treatment or the pathology with the patient, but indeed to actually treat it. In 1981 there was not a single state south of the border that allowed, for example, optometrists to prescribe therapeutic drugs. Now there are 27 or 28 of them. So while we are going in one direction in this proposal, other jurisdictions are going actually counter to that.

Mr J. Wilson: So what you are saying here is that the proposed scope of practice in the proposed act is really

arrowing your current practice. Again, I have asked other groups this: Do you have any idea why we are being asked to do that? Were there complaints? Are optometrists currently causing severe harm to patients?

Dr Carter: That is a very good question. We frankly do not know why the ministry or the review has come up with the decision it has come up with. Certainly there has been some ongoing communication with ophthalmology and we believe that ophthalmology has promoted ophthalmologists' interests.

Mr J. Wilson: We will have a chance to talk to the ophthalmologists.

Mr Carter: It has been somewhat difficult over the years. We attempted on one occasion and as an association did sit down. We did not really accomplish a great deal. Just recently our college has had an opportunity to sit down, and again there really was not an awful lot of consensus that could be drawn.

The problem in respect to ophthalmology is that at some point the policymakers with the Ministry of Health are going to have to come to the conclusion that you are not going to keep both groups happy. I really do not think you can keep both groups happy. The system we have in place as far as optometry is concerned has evolved over a matter of the last 20 years' time with the HDA. Optometrists are filling the role that was left open to them under the HDA and that role is going to be restricted under the new act.

Mr Waters: Where would the line be drawn between ourselves and the ophthalmologists, is it, the other group?

Dr Carter: The line would be drawn in the fact that optometrists do not treat pathology such as glaucoma, optometrists do not treat pathology such as cataract. It is not the intent of our submission today to ask for that, and it is not the intent of our proposals to the ministry to ask for that. If it was the intent of optometrists to do those procedures, then we would be asking for surgery, for example, and we have not requested a licence to act for surgery.

About the only thing that is contentious in our mind, when it comes to our proposals, is prescribing drugs. The prescribing drugs is in there for two purposes.

The first purpose is that we wanted to ensure that optometrists did not lose the capacity to utilize over-the-counter pharmaceuticals which are currently part of optometric practice. Indeed, there are 19 drugs that occur on the scheduled drug benefits that are currently used in optometric practice. We wanted to ensure that a not favourable interpretation by the courts would not eliminate the use of those over-the-counter medications.

The other function that we wanted to establish by prescribing drugs is the one that Alan Schwartz said in the first place. The legislative model was supposed to facilitate an evolution. We firmly believe that if the Ministry of Health looks very closely at our profession, down the road it will come to the same conclusion that optometrists can be better utilized by prescribing therapeutic drugs in this province.

The Chair: Thank you very much for your presentation. We appreciate your coming before the committee this afternoon.

1600

VISION INSTITUTE OF CANADA

The Chair: The next presenters, Vision Institute of Canada, come forward now, introduce yourselves, and you have 20 minutes for your presentation. We would ask that you leave some time for questions by committee members at the end of your presentation.

Dr Acs: My name is Dr Mira Acs. I am the past president of Vision Institute of Canada. Our current president, Jim Passmore, could not be here. With me is Dr Mitchell Samek, who is the executive director of the Vision Institute of Canada.

The Vision Institute of Canada is a non-profit charitable organization established in August of 1981. The institute is overseen by a voluntary board of directors. The institute is entirely funded through donations from individuals and corporations, service delivery programs, corporate and foundation grants. The institute does not receive any government funding in support of its programs.

Our mandate is to improve the quality of vision care services in the community. Our objectives that help us attempt to achieve this mandate are the support of a clinic providing high-quality vision care services, the sponsorship of high-quality educational programs and the support of scientifically based clinical research.

Some background on the clinical services that we provide: The vision institute operates a clinical facility in Toronto, staffed by optometrists. Our clinical staff provide over 4,000 diagnostic services annually in the following service categories: primary vision care, low vision care, contact lens care, binocular vision care, pediatric vision care, electro-diagnostic services, community outreach programs including geriatric services.

I will elaborate on one or two of these presently in order to provide you with some understanding of the scope of these services and their relationship to the proposed legislation.

Clinical education services first: In order to achieve dissemination of information relevant to the delivery of high-quality vision care, the vision institute sponsors continuing education programs for optometrists. These programs are attended by professionals from across Canada. The purpose is to enhance knowledge, skills and techniques of practitioners through lecture and workshop programs. These programs are accepted by the College of Optometrists of Ontario for renewal of licences.

We also provide education programs for other health professions including nursing, chiropractic, pharmacy and medicine.

In keeping with our commitment to the community, we freely provide public education presentations to various lay groups such as seniors organizations and parent-teacher groups.

In terms of our clinical research services, although the institute engages in various research projects, we are limited by our resources to projects wholly funded through corporate grants or foundation support. Some of our projects have included evaluation of new materials in contact lens solutions, evaluation of new instrumentation and the

epidemiology of diseases, disorders and dysfunctions of the eye and visual system.

The current legislation defines optometry as those services optometrists provide within their level of knowledge, skill and training. That is under the HDA. Thus, diagnosis and treatment or referral of a wide array of diseases, disorders and dysfunctions are managed by our clinical staff on a regular basis. The following will highlight for you some specific areas in terms of primary care.

Primary care: To dispel a misconception that glaucoma is simply high intraocular pressure, it should be noted that a large percentage of glaucoma falls into a diagnostic category of low-tension glaucoma. Additionally, several other categories of glaucoma of lesser or greater severity exist. The differential diagnosis is critical in the appropriate management of the disease.

Glaucoma work-ups include visual field testing, pressure measurements and extensive evaluation of the optic nerve heads and an extensive evaluation of the retina. Although not all-inclusive of full testing, these procedures are performed routinely by our staff. Patients are counselled accordingly and referrals or monitoring are made based upon professional judgement related to the test results. Irrespective of the fact that optometrists in Canada do not treat glaucoma, they must be able to diagnose the disease in order to manage the patient appropriately.

Low vision services: These provide opportunity for our staff to treat through optical and non-optical means a number of conditions which are non-medically or surgically treatable or beyond further medical and/or surgical care.

For example, macular degeneration is a common degenerative condition found principally among the elderly. It results in death of the vision fibres affecting central vision only, thus reading vision is impaired most profoundly. Over 99% of macular degenerations are not treatable medically or surgically. Significant improvement of function can be achieved through optical means, however.

Other causes of low vision include inherited conditions such as retinitis pigmentosa or the consequences of a cerebral vascular accident, a stroke.

The assistive devices program of the Ministry of Health currently has optometrists authorizing patients to enter this program through a completion of certification which includes the diagnosis of the cause of the low vision. The vision institute staff currently provide in excess of 300 complete low vision assessments annually. It is anticipated that this service will grow in excess of 25% annually for the next several years. In 1990 dollars, each of these patients is subsidized by the institute to the level of about \$60.

Let me give you some examples of electro-diagnostic services. This service includes the measurement of eye and brain wave recordings generated by a visual stimulus such as a flashing coloured light. Certain conditions which can be diagnosed with these tests include optic neuritis, which may be associated with multiple sclerosis; retinitis pigmentosa, an inherited degenerative condition resulting in night blindness and tunnel vision; and possible pituitary tumours.

Patient referrals for these diagnostic tests are received from neurologists, ophthalmologists, optometrists and

community agencies and facilities including Toronto Sick Children's Hospital.

Let me now finally talk about the impact of RHPA proposals. The limited scope of practice currently proposed by the RHPA will significantly impair our traditional role in the delivery of high-quality, efficient, accepted health care. It will prevent us from communicating with patients the diagnosis of the disease or disorder causing their visual symptoms such as cataract. This effectively interferes with the traditional patient-practitioner relationship.

The effect of such a limited view of optometrists' capabilities will necessitate over-referral of patients, with incumbent increases in the cost to the public. The increased costs will not only affect the OHIP payment system, but also affect the patient through the necessity to attend another practitioner's office with associated loss of income for the patient.

The current proposed scope of practice for optometry specifically denies the policy objective of promoting evolution in the roles played by individual professions and flexibility in how individual professionals can be utilized so that health services are delivered with maximum efficiency.

The proposed scope of practice fails to recognize the extensive level of professional education and clinical training undertaken by optometrists. The University of Waterloo program involves four years of education only after a minimum of one to two years general science at the university level.

Let me talk about a solution. The current legal accountability and professional responsibilities must be recognized. The scope of practice must include the diagnosis and treatment of diseases and disorders of the eye and vision system and the controlled act should recognize this change. It should be noted that this proposed change in scope of practice is neither status-seeking nor an attempt to obtain financial gain, but merely reflects the current practice of optometry in this province.

In summary, the vision institute has provided high-quality vision care to the community for the past nine years: services to the elderly, the multiply handicapped, the institutionalized, to those with strokes, infants, children and to patients of all racial and ethnic origins. Patients have sought our counsel with respect to the diagnosis, treatment and management of their various eye and visual system problems. Irrespective of the ultimate management including referral as necessary, we have openly communicated our diagnoses and management options with them. On behalf of our patients and their families, we ask that you amend the proposed legislation and grant optometrists the right to continue to serve the public in the same professional manner they have for decades.

The Chair: Thank you very much for your presentation.

Mr Waters: Maybe I am slow on the uptake or something, but I seem to be getting the opinion here that there is going to be a major change. I represent a very rural riding I am somewhat concerned. From what you are saying and what other people have said, what is going to happen to the people in my riding? Let's say a small rural town in Muskoka or up in the Collingwood area, these small rural communities, are they going to have to go to a place like

carrie to have their eyes checked? Under this new thing, is it what is going to be a standard practice?

Dr Acs: Yes. For some situations, for certain types of patients, yes, they are going to be going someplace else—after they see you, because they are still going to go see the optometrist.

Mr Waters: But you are saying that they have been safely treated at the optometrist—

Dr Acs: At the optometrist's office. Yes, I am saying that.

Mr Waters: And a proper diagnosis has been made, and now you are not even allowed to tell about the diagnosis. You have to—

Dr Acs: We have been sort of told that what you could tell them, couched in the language, is that you could say perhaps, "I think you may perhaps have—"

Mr Waters: Okay. Can I have a supplementary to that to the ministry? Could they respond to that answer?

The Chair: Mr Wessenger.

Mr Wessenger: I will turn this over to the staff, because I think it does require some clarification.

Ms Bohnen: First of all, in case there has been confusion about the diagnosis issue vis-à-vis optometry, then from some of the other professions that you have heard concern about, I would like to remind you that the scope of practice of optometry recommended by the review does include diagnosis of vision and oculomotor dysfunctions of the eye. What you have heard from optometrists is that they believe that they diagnose, in addition to vision and oculomotor dysfunctions of the eye, diseases and disorders of the eye and vision systems. So, first of all, that is what the issue is about. It is about the extent of the ability to diagnose.

The review came to the conclusion that optometrists do not diagnose all diseases, all disorders, all dysfunctions of the eye, which is what ophthalmologists do, but rather that they do something more confined than that, and that is, as I just spouted to you, the diagnosis of vision and oculomotor dysfunctions of the eye.

Now, of course, in addition to conclusively diagnosing those dysfunctions, it is well recognized that optometrists assess the eye and vision system and are quite capable of identifying the symptoms of cataract, the anomalies of pressure that indicate glaucoma, of monitoring patients with those conditions and of referring them to ophthalmologists for treatment at the appropriate time.

That being the case, it was not the review's belief or intention nor has it been the government's belief or intention that this would alter current practice by optometrists. So that no, patients who had been going to their local optometrist would not find themselves in a position of having to drive 60 miles to the closest city with an ophthalmologist.

Mr Waters: Especially when they cannot see.

Ms Bohnen: Especially when they cannot see.

Finally, just because you heard about it, the scope of practice of optometry in the Health Disciplines Act says, "The practice of optometry means the services usually performed by an optometrist, including the measurement and assessment of vision other than by the use of drugs, except

such drugs for such purposes as are described by the regulations, the prescribing and dispensing of ophthalmic appliances and the prescribing and providing of orthoptics"—and it goes on a bit. But I guess the salient part is, "The practice of optometry means the services usually performed by an optometrist, including the measurement and assessment of vision." The review concluded that the services usually performed by an optometrist are what you see proposed in the Optometry Act.

The Chair: I have a further comment from the deputation, and then a question by Mr Wilson.

Dr Acs: I would like to respectfully disagree with what was just said, and what was said was that optometrists are quite capable of identifying X and then are capable of monitoring it. With all due respect, unless you are able to communicate what it is that you are identifying to the patient, you cannot expect the patient to keep coming back to you for monitoring if the patient does not know why he is coming back for monitoring. They are going to travel to somebody else who will tell them, "You're coming back for the monitoring of cataracts."

The Chair: A clarification.

Ms Bohnen: I am sorry. I should have gone on to say that of course the outcome of an assessment can be communicated to a patient. That is the same for optometry as for all of the other professions you have heard from who are justifiably concerned that they can tell patients the outcome of an assessment.

Mr J. Wilson: This is really a question to the ministry. Do we have any independent legal opinions to back up the ministry's belief that you have not changed the status quo, for instance, in the practice of optometry?

Mr Wessenger: I will refer that to ministry staff, but the legislation has, in effect, been drafted in accordance with the intent of the—

Mr J. Wilson: I trust in our legal department, but I was just wondering if we had any independent opinions on this.

Mr Wessenger: To be fair, there seems to be a confusion among various groups about the difference between assessment and diagnosis. There was never any intention, as I understand it—

Mr J. Wilson: It is not just among groups; it is among legislators, I assure you.

Mr Wessenger: There is certainly no intention to limit the assessment of problems and the communication with respect to that assessment, and I think that should be made clear to the committee as well.

Mr J. Wilson: I gather the government would not bring this forward unless it was comfortable with it. We have had group after group saying they are not comfortable with it. We have some legal opinions in appendages to briefs. I am wondering if the government itself has any independent legal opinions backing up the fact that we should be comfortable with the legislation it puts before us.

Mr Wessenger: Perhaps I will just let ministry staff add to what has been said.

Ms Bohnen: As you have heard, different groups are uncomfortable with different aspects of the diagnosis-assessment issue. Most of the groups you have heard from, prior to the optometry groups, are uncomfortable because they have not been given the authority to diagnose at all, and therefore all they can do is assess. In various ways I think they have told you that they need some comfort that they can continue to assess their patients and communicate the results of those assessments. I think you have heard the minister, when she came to the committee, say that she anticipates the need for some amendment in this area and was hopeful to hear the advice of the committee, but that is quite a different issue from the issue of whether a group that has been authorized to diagnose has been authorized to diagnose the correct subset of health conditions, and that is the issue that optometrists are uncomfortable with.

I think the issue was stated correctly to you, that optometrists believe that they diagnose all diseases, disorders and dysfunctions of the eye and vision system. The review did not agree with that. The review looked at what optometrists do and said, "We agree on what you do; we disagree on the characterization of what you do." I do not think the ministry considered a further legal opinion about that issue as being really helpful to the point.

Mr Cordiano: To carry on with this: In a sense, the scope of practice, as defined by the review, essentially is unchanged. It is a status quo situation that we are bringing forward in the legislation, and it more clearly defines what optometrists do.

Ms Bohnen: The Health Disciplines Act uses those rather indistinct words, "the services usually performed by an optometrist." The review looked at what optometrists actually do, and said, "We describe that as diagnosis of dysfunction and assessment of other health conditions." The review said, "Look, that's how we write down the status quo." What you are hearing from optometry is that, "No, the right words to describe what we do are diagnosis of all of these health conditions." That is what the argument is about, I think.

Mr Cordiano: Let me quickly ask the optometrist: With respect to diagnosis, currently you are, in your opinion, diagnosing, say, a disease as it comes up. Is that what you think you are currently doing?

Dr Acs: Yes.

Mr Cordiano: And the legislation would now prohibit you from doing that, correct?

Ms Bohnen: The legislation would say, "You can diagnose dysfunctions. You may not diagnose diseases. However, you can assess patients and tell them the results of the assessments," and where that assessment includes a sign or symptom of a disease, certainly that could be communicated to a patient.

The Chair: Thank you very much for the clarification. I know that in the course of these hearings there will be an opportunity to pursue this and other similar matters on other occasions. I want to thank you for your presentation.

For the information of all committee members, the video that was presented by chiropraxy is available in the clerk's office and will be available to any member of the committee or anyone who is sitting on the committee; for that matter, any interested member of the Legislature would like to view it, until such time as the committee has completed its deliberations. Actually the clerk has informed me that they can make a copy of it so that it will be available indefinitely.

The second item of business before we adjourn is a report of the subcommittee, which met briefly the other day and agreed to meet on September 16, which is a Monday, and on September 19, which is a Thursday, not to have witnesses and public hearings but to have ministry-specific presentations. On the 16th and 19th Mr Schwartz is coming. We had considered the other dates during that week but they are the high holiday dates, and so the determination should be the 16th and the 19th.

Mr Martin: Again, with all due respect, the 16th and the 19th, for people who travel from the north, makes for a big problem if we want to spend any time back in our constituencies before we go into the House. I just want to put that on the record.

The Chair: I understand the problem was that the ministry staff were not available on the 17th, and with the holiday period out of consideration the committee determined that if it was necessary we would meet on the 19th. Excuse me just one moment.

For the information of the committee and the subcommittee, we will discuss it further. It may be possible, provided we adjourn not too late on the 17th, to actually meet the 16th and the 17th until approximately 3 o'clock to help with that problem of out-of-town participation. The subcommittee will consider the matter further, and I will report back to the committee at another time. Thank you.

The committee adjourned at 1620

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First Session, 35th Parliament

Official Report of Debates (Hansard)

Tuesday 13 August 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mardi 13 août 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
Greffier : Lynn Mellor



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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 13 August 1991

The committee met at 1002 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES

ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi de 1991 sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: I call the meeting to order. We are holding public hearings on the Regulated Health Professions Act and its companion legislation, Bills 44-64, inclusive. We have agreement from the Progressive Conservative caucus that we can begin the hearings on time and expect that they will be here very shortly.

The first item of business is the tabling of the subcommittee report, which I believe all members have. With the agreement of the subcommittee, the committee will meet Monday, September 16, and Mr Schwartz, the co-ordinator of the Health Professions Legislation Review, will be in attendance. The agenda for the afternoon will be to have a briefing from ministry staff.

Second, on September 17 we would be able to have people from the Ministry of Community and Social Services as well as any other experts we would like to invite in on those two days. One request that has been made is that because of the high holidays on the 17th, if we could adjourn by 3 pm and perhaps work into the lunch hour if we needed additional time, that would be appreciated.

That is the report of the subcommittee. Can I ask for agreement and concurrence from the committee at this time? All in favour for approval? Any opposed? Agreed.

ONTARIO ASSOCIATION OF MEDICAL RADIATION TECHNOLOGISTS BOARD OF RADIOLOGICAL TECHNICIANS

ONTARIO ASSOCIATION OF RADIOLOGY MANAGERS

The Chair: I welcome the Ontario Association of Medical Radiation Technologists, the Board of Radiological Technicians and the Ontario Association of Radiology Managers. Introduce yourselves, and you have 20 minutes for your presentation.

Mr Hamilton: I am John Hamilton, representing all three bodies. I will ask the members to introduce themselves as we go across.

Mr Roberts: My name is Richard Roberts and I am the representative from the Ontario Association of Radiology Managers.

Ms Morgan: Janet Morgan, chairman of the Board of Radiological Technicians.

Ms Lachance: Mary Jon Lachance, past president of the Ontario Association of Medical Radiation Technologists.

Ms Pope: I am Hilda Pope. I represent the magnetic resonance imagers.

Ms Ayre: I am Mary Ayre. I am representing sonographers from the Canadian Society of Diagnostic Medical Sonographers, Ontario region.

Mr Scott: I am Dave Scott. I represent the nuclear medicine technologists, and I am also a member of the Board of Radiological Technicians.

The Chair: I would ask that you leave some time at the end of your presentation to allow for questions from the committee. The time begins now.

Mr Hamilton: The submission of the three bodies is in the hands of the members of the committee. I intend to refer to a few points very briefly and leave most of the time for questions, if that is appropriate.

The first point deals with Bill 43 and is a matter of considerable concern. In clause 28(b) it provides that a student must be "under the supervision or direction of" a registered person in order to perform certain acts. There is no definition of either of these terms. It appears to us it should be "supervision and direction."

Looking at it in its worst possible light, a registered person could, from off the site, phone a student and say do a particular thing. The student is under the direction of the registered person but not under the supervision, and no matter how careful the student is, no matter how dedicated the student is, the public may still be at risk because of being treated by someone who is not registered. It is our submission that the word "or" should be changed to "and." It is again a matter of protecting the public.

The second point has been partly covered by the proposed amendments to Bill 54; that is, it is now provided in the proposed amendments that not only is ionizing radiation covered, but also any other form of energy prescribed by regulation. This is for diagnostic purposes. However, this does not cover therapy. There are other forms of energy now being used for therapy and there may well be other forms coming downstream. In this increasingly technological age, who knows what is going to turn up next week?

The submission is that the same provision should be made for therapy as for diagnosis; that is, provision in the regulations to add other forms of energy if, as and when appropriate. Again, it is a matter of protecting the public, but also a matter of not having to come back to the House to allow some other form which needs to be added. A matter of regulation is, as you all know, somewhat simpler than getting legislation passed, although there are times when regulations you wonder a bit, too.

The other point we have is strictly an editorial one. In Bill 54, I think there is a misprint. It refers to members of council who are "selected" and I think it means "elected." To my mind, it does not seem to make complete sense saying "selected." But there are members of council who are "elected," and if the council may make regulations dealing with the matter of election of its elected members, obviously council cannot do anything about those who are appointed by the Lieutenant Governor in Council.

Those are the three points. I have the experts with me who may, I hope, be able to answer any questions.

1010

Mr Beer: Thank you very much for your submission. I think it is probably fair to say for all of us lay members of this committee that your field, one always has the sense, is continually pushing the envelope. I think how we deal with new developments then does become important. I just want to make sure I understand your point 2 you raised, so that on page 3 of your submission that is the way you would suggest we deal with that, which would then mean that required regulations would be able to be passed to bring that under.

Mr Hamilton: Yes.

Mr Beer: Did this come up when Schwartz was looking at this, or has this appeared in any earlier form?

Mr Hamilton: It has been discussed for many years and for a long time the answer was, "There aren't any other forms of radiation which are liable to do any harm to people." As far as I know, I pass to the experts, but I think the jury is out on a number of forms of—

Mr Beer: If this was not there the concern would be, you would need to come back for a specific change in legislation to then be able to do that procedure.

Mr Hamilton: Right.

Mr Beer: On the supervision and direction issue, in terms of your present rules of operating, what is the situation?

Mr Hamilton: Supervision.

Mr Beer: Okay, so just that one word is used and therefore is your concern that with the two, one is a lesser meaning, or what does it mean?

Mr Hamilton: Yes, direction could mean a lot less than supervision.

Mr Owens: Further to Mr Beer's question around the college forming regs as opposed to having to come back to the government, how would you see that furthering public protection with respect to other forms of energy?

Mr Hamilton: It would not be the college that made the regulations; it would still have to be regulations made by the Lieutenant Governor in Council. If you mean not having to come back to the Legislature every time some new form of energy has been either adapted, used or for any other purpose, it is already set up that way for diagnosis in the proposed amendments to the legislation. But I understand that right now there are forms of energy other than ionizing radiation used for treatment of cancer patients. There is heat and light to a certain extent.

Mr Owens: So in terms of serving the public interest, that would mean it would get things, newer modalities of treatment, on track faster, and perhaps be less costly.

Mr Hamilton: And being sure they are being used by persons who are properly trained; that is the main point. At present, if someone comes up with some new form of energy which is not regulated in any way, anybody can use it on patients, which in our view is entirely inappropriate, not to say dangerous.

Ms Lachance: One point to bear in mind also is that in our line of technology a lot of the harm may not even be realized until there has been another generation, so the indiscriminate use of an energy could go on for years and years and nobody would really appreciate that there was a problem. We bumped our nose many years ago the hard way so we are a little more careful now and we say that if we could control this initially, until we absolutely know there is no harm—because it takes so long for it to show.

Mr Hamilton: It must be remembered that M^{me} Curie died of radiation burns.

Mr Wessinger: Yes, I believe we could have some clarification by ministry staff on some of these items.

Ms Bohnen: In terms of the proposed further amendment to the scope of practice, I think it should be pointed out that the scope of practice statement describes the activities members of the college engage in; it does not control the performance of any particular procedure. One of the controlled acts in section 26 of the RHPA is ordering or applying prescribed forms of energy. The intention is that the minister will make regulations under the RHPA, identifying as they develop or as risks are identified those forms of energy the ordering or application of which are restricted to particular occupational groups. So making an amendment to the scope of practice itself does not provide any control over who can prescribe or apply particular form of energy. That is handled elsewhere in the legislation.

The Chair: Thank you very much for your presentation. I have no further questions from the committee.

The other point I would make today, which I did not mention yesterday to those who were here, is that if organizations or individuals wish to communicate with the committee, they may do so at any time in the form of a letter or written brief between now and the end of the committee hearings. Please feel free to do that.

COUNCIL OF ONTARIO FACULTIES OF MEDICINE

The Chair: I call now the Council of Ontario Faculties of Medicine. Welcome to the standing committee on social development. Please introduce yourself. You have 20 minutes for your presentation. I would ask that you leave few minutes for questions from the committee at the end if possible.

Dr Provan: I am John Provan. I am the associate dean for post-credit education here in Toronto. I am representing the Council of Ontario Faculties of Medicine. That is the body that represents the five medical schools in Ontario. sit on that committee.

COFM, as it is called, has no major concerns regarding the act respecting the regulation of the profession of medicine.

cept for the proposal that the number of university representatives on the council of the College of Physicians and Surgeons of Ontario be reduced from its current number of five, ie, one for each school, to three.

There are various reasons why we think this is inappropriate and why we have rejected this proposal. First, as currently constituted, the act prevents any full-time member of a medical school from being eligible for election to the College of Physicians and Surgeons of Ontario. This means that the medical schools as such cannot be represented in the electoral process. You could say we could change that situation to permit people to be elected, but I think there is a risk that then the regular representation from the rest of the profession in the province might become overbalanced.

COFM believes that a reduction in the number of university representatives on the council of the College of Physicians and Surgeons from five to three would primarily deny access to council of the breadth and depth of experience of the university representatives. These individuals over the years—I think there has been a university representative on the CPSO council since council was first constituted—have provided a unique resource which I think would not otherwise be available.

The university representatives have a unique administrative experience. They represent the teaching hospitals, where they often have positions of leadership. They represent the medical schools and they bring to council the representation of national and international bodies that these individuals represent as well. They tend to be leaders in the profession and they have often been chairmen of departments of medicine, surgery or other specialties as well as hospital department heads. That leadership has been very useful to the council of the CPSO in the past.

They also provide professional expertise in issues that are often not clearly understood either by the professional members of council or particularly by the public representatives on the council. These relate particularly to education, in so far as it affects both undergraduates and post-graduates in training, and particularly with regard to research. Indeed, it has been pointed out to me by people from the CPSO that the university representatives are actually the linchpin which provides experience for the CPSO in terms of medical research.

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The university representatives also have a clear understanding of issues which relate to registration and licensure. These are sometimes complex and in the interests of public protection need careful elucidation. As these are issues with which the university representatives are dealing all the time, they provide special expertise in this area. They also bring regional representation to the CPSO, and that, in itself, may be important.

I think it is also important to note that in the past these university representatives have served council extremely well. Many of them have become presidents of the College of Physicians and Surgeons. They have represented various specialty committees, such as the registration committee and the education committee of the college. They are articulate representatives of the profession. They are gen-

erally at the forefront of changes, and in the past they have provided a very useful means of interaction between the public and the college by seeing where changes in medical education and medical practice are taking place, so they have been able to improve that. Somebody wrote the other day stating that these five representatives have performed incalculable service to the college.

Finally, we believe that these university representatives, above all, have the time to serve the college well. This is a very time-consuming process, and those involved in private practice solely are often not as easily able to spend the time doing this. University representatives have a process in place which enables them to spend their time, and as university representatives, they are spending a lot of their time thinking. They are looking ahead and we believe that their creativity and innovation would be lost to the council if the numbers were reduced.

I think it is also important to note that the five universities themselves represent different facets of medicine in Ontario. Ottawa, for example, represents the francophone component. McMaster tends to take more mature and a higher percentage of female students. Kingston represents a small, compact school in a small area, and Toronto has a huge medical resource with many of the leaders in the profession, whose expertise might well be lost if they were not able to be present at the discussions of the council of the CPSO.

Mr J. Wilson: Thank you for the presentation. What does the CPSO itself think about your proposal?

Dr Provan: The CPSO has discussed this issue and, I think virtually unanimously, is against any reduction of the university representatives from five to three. They had felt, I think, very strongly that some of the issues I brought up are being of incalculable service to the council.

Mr J. Wilson: Do you have any idea how three crept into the draft legislation?

Dr Provan: No, I do not. The initial numbers put forward by the previous government reduced it from five to three, but it is my understanding that the council is not in favour of this.

Mr Grandmaitre: Maybe my question would be better directed to the ministry. How did the recommendation come about for the reduction of representatives from five to three?

Mr Wessinger: I could take a guess at that answer, but I will turn it over to ministry staff.

Mr Burrows: It is unfortunate Linda is not here, because she was with the review, but it is my understanding that the review carefully considered this issue and made its recommendation to maintain an overall balance on college council. Also, it looked at the fact that medicine alone would have had a very sizeable number of academic members compared to other professions where, at most, they had two, and many only had one academic member, and the principle of equitable treatment entered into this. Perhaps Linda could elaborate a little bit on this now she is back. They are asking, Linda, for the history of the five versus three.

Ms Bohnen: The review considered the various professional interests and the public interest to be represented on the college council. In addition, it becomes something of a juggling act when you are trying to increase the proportion of public representatives on the council. The review concluded that there should be a maximum of three academics on the council of the College of Physicians and Surgeons, that this was the appropriate proportion of academic involvement in the affairs of the council. That has been retained in the bill and will be retained in the bill, even though the proportion of public representatives has been proposed to be increased, as you know, to just under half. So the CPSO will still have more academics than any other college council.

The Chair: Thank you for your presentation. We appreciate your appearing before us today. Next is the Governing Board of Dental Technicians of Ontario. Are they not here yet? In that case, we are a few minutes early. If any members of the committee would like to raise any issues at this point with the ministry, we can.

Mr Waters: I would like some clarification of this five versus three. How many people sit on the board and what do they represent?

Ms Bohnen: In this version of Bill 55, the council is composed of 16 elected professional members and nine persons appointed by the Lieutenant Governor in Council—those are the public members, the lay people—plus three academics. That will be revised again because of the minister's commitment to increasing the number of public members to just under half, but that is what appears now in the bill.

Mr Owens: I would like to pursue something we started looking at yesterday, around the chiropractors especially—it seemed to be the most apparent—and that is the issue of being able to assess and treat, but not being able to communicate the reason why you are treating. I am just wondering how we have made that leap from assessment to treatment without having the bridge of being able to communicate?

Ms Bohnen: We have not. What they were saying was that because chiropractors have not been authorized in their controlled acts to diagnose, it is their view that they cannot communicate the results of an assessment. The ministry's position and the government's position is that although they cannot diagnose, they certainly can assess their patients and communicate the results of the assessment. So we disagree with them as to the effect of not being authorized to perform the controlled act of diagnosis. That is one aspect of the issue you have heard many groups speaking about. If they cannot diagnose, how can they be assured that they can nevertheless assess their patients and discuss the results of the assessment with their patients?

Mr Owens: But without specific language around communication, I am not sure that assessment is really tandem—assessment and communication. Not having legal training and trying to shuffle through the nuances of the language, I find it problematic in the way that it is written.

Ms Bohnen: You are not alone among individuals and groups who have problems with the way it is written. I

think that is why the minister said she hoped to be guided by the committee in making some changes that would still protect the public in terms of restricting who can diagnose, but would comfort both professional groups and the public that they can be properly assessed and find out the results of the assessment.

The Chair: Any further discussion or questions of the parliamentary assistant or ministry? Is the Governing Board of Dental Technicians of Ontario here yet? The committee will adjourn for 10 minutes and reconvene at 10:40.

The committee recessed at 1030.

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GOVERNING BOARD OF DENTAL TECHNICIANS OF ONTARIO

The Chair: I call on the Governing Board of Dental Technicians Of Ontario. Introduce yourselves to the committee. We would appreciate it if you could leave a few minutes at the end of your presentation, if you wish, for questions from the members of the committee. You have 20 minutes, beginning now, for your presentation. Thank you for joining us this morning.

Mr Doel: I would like to introduce myself, Jim Doel, as chairman of the governing board of dental technicians. With me is our legal counsel, Peter Downard; Peter Ferraro, RDT, and a member of the governing board of dental technicians; and Dan Huber, RDT, and past chairman of the governing board of dental technicians.

The Governing Board of Dental Technicians of Ontario strongly endorses the many important steps which have been taken to rationalize the legislation—excuse me, please. I am just going to get some water, here. I am a little nervous.

The Chair: Do not be nervous.

Mr Doel: No, I will not be nervous.

The Chair: No, I can tell. The committee is very friendly this morning. Yesterday I was not sure, but I can tell this morning that everyone is in a good mood. So please do not be nervous and just continue with your presentation.

Mr Doel: The Governing Board of Dental Technicians of Ontario strongly endorses the many important steps which have been taken to rationalize the legislation applicable to all the health professions in Ontario and applauds the very substantial efforts of those who have done so much to move this process towards fruition.

That being said, the governing board today wishes to explain to the members of this committee the reasons for the serious concerns we have about the Regulated Health Professions Act, 1991, and the Dental Technology Act, 1991. Our concern is shared by many other relevant participants in the dental health care system and we understand that those concerns are also fully appreciated by the Ministry of Health.

Our concern is that the RHPA and the the Dental Technology Act, 1991, as presently worded do not contain measures sufficient to protect the public. This is a matter of profound concern for the governing board, which by statute has been charged with the obligation of regulating the practice of dental technology in the public interest for almost 50 years.

In our submission today, we wish to provide you with an explanation of why it is that the adequate regulation of dental technology is so important. Second, we will explain why the RHPA and the Dental Technology Act, 1991, as presently worded do not yet adequately regulate the profession. Third, we will outline for you our proposed solution to this problem, which we understand is supported by all the relevant partners in the dental care field, as well as the Ministry of Health.

Through our submission today, we hope to provide you with some assistance in understanding the need for and the purpose of a statutory amendment which you will be dealing with during the clause-by-clause stage of your deliberations.

The problem posed by the RHPA and the Dental Technology Act, 1991, as presently worded is best understood when one appreciates the reason why adequate regulation of the dental technology profession is necessary.

Appropriately qualified dental technologists serve as critical links in the dental health care process. They ensure patients receive dental appliances which are constructed in accordance with dentists' prescriptions and that the dental appliances have been produced using appropriate materials and methods.

The risk of harm to the public that may result from the inappropriate practice of dental technology is considerable. Potential harm arises from the possible use of harmful or toxic materials in the construction of dental appliances. The same risk arises from biologically incompatible design or workmanship. In either case, the patient can be harmed both physically and emotionally.

It must be clearly understood that mistakes or improper choices with respect to these matters may be undetectable by the dentist. Almost all dental appliances manufactured in Ontario are produced outside of dentists' offices and beyond dentists' control or supervision. Because faults in material or workmanship in dental appliances may only be detectable at the point of their construction, dentists place heavy reliance upon the professionalism of dental technologists.

In its submission to the committee, the Royal College of Dental Surgeons of Ontario has stated its strong view that, "The college understands and supports the concerns of the governing board of dental technicians that the quality of dental prostheses be protected by ensuring that only qualified persons be permitted to dispense them."

Similarly, the Ontario Dental Association stated in its submission to the Health Professions Legislation Review:

"Dental technicianry is an integral part of the practice of dentistry. Without their reliable, professional contributions, the practice of dentistry in Ontario would no doubt be much lower on the world scale than it is—second to none. We would ask the review to recommend that anyone practising dental technicianry in Ontario be licensed by the college of dental technicians. This would ensure that continuation of standards which have taken generations to develop and on which we have all come to depend."

The fundamental deficiency of the RHPA and the Dental Technology Act, 1991, as proposed is that they do nothing to ensure that control is exercised over the materials and methods used in dental technology by an appropriately qualified person. Under the RHPA and the proposed

Dental Technology Act, 1991, unqualified persons wishing to practise dental technology would be free to do so without restraint, as long as they did not call themselves dental technologists or dental technicians or otherwise represent themselves as being qualified to practise as dental technologists or in a specialty of dental technology. The legislation in its present form would do nothing to prevent unqualified persons from carrying on the practice of dental technology under some other title.

Ironically, the Dental Technology Act, 1991, creates a more elaborate administrative structure for the regulation of the profession of dental technology than has ever existed before. However, by omitting any requirement that a qualified person exercise control over the materials and methods of dental technology, it would leave the regulation of the profession without any meaningful foundation and would leave consumers without adequate protection. If left unamended, the RHPA and the Dental Technology Act, 1991, would result in the effective deregulation of dental technicians in Ontario for the first time in almost 50 years.

The problem is made all the more troubling by the fact that the need for effective regulation is currently greater than ever. Committee members may be shocked to learn that a substantial number of commercial dental laboratories are now operating illegally in Ontario. These are laboratories which carry on their activities without the slightest involvement of a registered dental technician. The governing board has undertaken a test case under its current legislation in order to address this problem.

Under the Dental Technology Act, 1991, as presently worded, such illegal operations would continue unhindered, as long as no one involved with them called themselves members of the college of dental technologists or otherwise held themselves out as appropriately qualified persons.

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The governing board strongly believes the government must ensure that the inappropriate practice of dental technology does not continue. We are therefore asking the members of this committee to approve amendments requiring that a member of the college of dental technologists supervise all dental technology work performed in this province. Without such a requirement, this government and the governing board will be powerless to protect the public from the provision of substandard and potentially harmful dental care that unscrupulous operators may provide in an unregulated environment.

In addition to the dramatic impact the proposed legislation would have upon the protection of the public in Ontario, it should also be noted that inadequate regulation of dental technology would also have a negative effect upon the post-secondary education of dentists in Ontario and on the provincial taxpayers.

The University of Toronto and the University of Western Ontario have both stated their recognition of the reliance placed by dental technologists upon qualified dental technicians. In particular, they have pointed out that they have increasingly shifted their undergraduate program away from dental technology to other priority areas, such as biological sciences. The dean of the faculty of dentistry of the University of Toronto has stated that such changes "were

only possible because we were secure in the knowledge that there existed a sound infrastructure to the dental profession, namely, a well-trained and regulated licensed dental technician." If this practice of dental technology were to be effectively deregulated, the current ability of dental faculties to rely upon the dental technology profession would be dramatically undermined.

The University of Toronto has estimated that unless the wording of the Dental Technology Act, 1991, is changed, university dental faculties would have to add an additional one year to the curriculum, at a cost of \$3.5 million per year and \$2 million in capital costs. Dental students would also be faced with an additional year of study and an increase in the cost of their education of approximately \$10,000 per student.

For its part, the faculty of dentistry of the University of Western Ontario has stated through its dean:

"There is a very strong feeling within this faculty that the abandonment of dental technology as a licensed act would have grave implications for dentistry and would adversely affect the public. It is a retrograde step and we would that it will not come about."

In these circumstances, all of the participants in the legislative review process have acknowledged that as presently worded, the Dental Technology Act, 1991, does not provide adequate measures to ensure the appropriate practice of dental technology and that it must therefore be amended to ensure an adequate protection of the public.

In the governing board's view, protection of the public may be secured by a statutory amendment requiring that no dental technology work may be performed in Ontario unless that work is done under the supervision of a member of the college of dental technologists. The supervision of a properly qualified member is essential to ensure that appropriate procedures are followed and that satisfactory materials are used in the construction of dental appliances. This policy is widely supported by participants in the dental care field, which includes the Association of Registered Dental Technologists and the Commercial Dental Laboratory Conference.

It is important that the members of this committee understand that the government has also acknowledged that the RHPA and the Dental Technology Act, 1991, as presently framed do not satisfactorily achieve the goal of protecting the public. It is the governing board's understanding that the Ministry of Health agrees in principle with the need for an amendment which will better protect the public by ensuring that dental technology work is supervised by a member of the college of dental technologists.

The governing board wishes to make clear to the committee that it is absolutely fundamental that the statutory amendment achieve two goals: First, it must ensure that no person may perform dental technology functions unless that work is supervised by a member of the college of dental technologists; second, where dental technology work is performed and is not supervised by a member of the college, the amendment must ensure that both the person or business organization carrying on the business and the unqualified person supervising the work are liable to a provincial offence.

In the governing board's view, these purposes can be achieved by the provision which we have outlined in page 10 of our submission.

The purpose of this amendment would be (1) to ensure that dental technology work is not performed unless it is supervised by an appropriately qualified person, and (2) to ensure that where dental technology work is performed in the absence of appropriate supervision, all relevant parties are liable to a provincial offence. In this regard, particularly given the existing problems regarding the growth of illegal commercial dental laboratories, the governing board considers it to be particularly important that the amendments clearly and specifically ensure that all these business organizations carrying on inappropriate activities be liable to an offence.

At this time, the governing board understands that legislative counsel has been instructed to prepare a statutory amendment which will reflect the Ministry of Health's agreement in principle that the dental technologist must be supervised by an appropriately qualified person. With other relevant parties, we await the result of legislative counsel's work. The details of appropriate exemptions from our proposed amendment for professionals who derive adequate expertise from other training, such as dentists, are also currently being refined. We are confident, however, that the existing consensus on the needs and goals of adequate regulation among all relevant parties will ensure that satisfactory amendments will soon be in a final form, and that it will form an appropriate foundation for the adequate regulation of the dental technology profession in the public interest.

The Chair: Thank you very much for an excellent presentation. Some members would like to ask questions. We have approximately four minutes. I ask that you be aware of the time.

Mr Owens: Mr Doel, thank you for the excellent presentation. I am really pleased that you raised the issue of illegal labs operating, because in my meetings with members of your industry these rumours surfaced. You can have the greatest regulation in the world. My question is, quite simply, how is it going to be more enforceable than what we have currently proposed? If we accept your amendment, how would the government or the industry be able to enforce that to ensure that these illegal operations are not up and running?

Mr Downard: In our view the amendment we propose will just go all that much further to make sure this activity is stopped. We see a loophole in the act as proposed that one can drive a truck through and we think the amendment we have proposed will close that loophole. As a lawyer, I am aware there probably has never been a piece of legislation invented that another lawyer could not find something around, but the fact remains that we strongly believe the amendment we have proposed will go a very long way towards addressing this serious problem.

Mr Beer: It is probably fair to say that all this legislation is going to provide lawyers with some interesting challenges regardless of what amendments come through.

I take it, from the end of your presentation that if these amendments that are going to be coming from the

government are what you think they might be, that will end the problem. Is the issue then around the dental laboratories association? There is an Ontario or Canadian association. Are they concerned or are they the ones who did not want this change made, or where is the conflict here? Who is saying, "No, we don't want all these acts to be directed by some other body"? Where is the opposition here?

Mr Downard: As we understand it, doing the best we can to canvass all the relevant opinions, there is indeed now a consensus in the dental technology industry that dental technology should only be carried on where it is supervised by a member of the future college. That policy appears to be the subject of a firm consensus. We are in the process of refining the precise mechanism by which the policy can best be realized, and in that regard we are dealing on an ongoing basis with all relevant parties. But we are very confident that there is a firm foundation of consensus as to the essential policy.

Mr Beer: That being done, then, you would be content with the act as it would then be.

Mr Downard: That is the case.

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Mr J. Wilson: I have a quick question to get an understanding of what the current status is. You mention in your brief that there are a number of commercial entities carrying on unregulated, I gather, and unaccountable. How is that the case? You have a college now. One would assume it was supposed to be doing this or would have been given the authority to do this.

Mr Downard: There have been some concerns about the adequacy of the language of the current legislation, which I will not dwell on further here. Also, until relatively recently there was only a nominal fine structure in place for violations of the legislation, which apparently gave some operators an incentive to disregard the law and made it more difficult to face the task of enforcing the law.

The Chair: Thank you very much for your presentation. We appreciate your appearing here this morning. Please feel free at any time over the course of these hearings to communicate further with the committee in writing, although you have presented us with a very substantial brief.

Mr Jackson: Madam Chairman, would it not be appropriate, where a deputation presents a point that the government has already agreed to a substantive change, that we have that statement corroborated? That would have been my question to the ministry.

The Chair: If you wish. There are times we can do that or you can ask to do that at this point, if you like.

Mr Jackson: If there is any conflict I would like that to be flagged, if there is a disagreement on the part of the ministry. I am accepting the statement, but it is an agreement which implies to the other parties—it would be helpful; that is all.

Mr Wessenger: Yes, we are working on an amendment, substantially as represented, to try to accommodate the interests of the dental technicians as well as the dental profession, the medical profession.

The Chair: That will be presented at a later time?

Mr Wessenger: Yes, it will be presented.

Mr Jackson: It is helpful at this point to know that, and I appreciate that.

The Chair: For the advice of members of the committee, for issues such as Mr Jackson has just raised, that is different than a questioners' list. If you signal to me that you have a question for the parliamentary assistant, I will keep a separate list and do that at the end of the presentation.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Chair: Next is the Psychiatric Patient Advocate Office. Welcome. You have 20 minutes for your presentation, if you would begin now. We ask that you leave a few minutes for questions at the end.

Mr Giuffrida: I will indeed; I am David Giuffrida, legal counsel to the Psychiatric Patient Advocate Office. We are a quasi-independent program of the Ministry of Health that has been working in the area of rights of psychiatric inpatients in the 10 provincial psychiatric hospitals since our program began in 1983. We have enjoyed, since we began, the latitude to address committees such as yours and of course in doing so do not speak for the ministry.

I want to comment on several aspects of the Regulated Health Professions Act, Bill 43, that have ramifications for the rights of psychiatric patients and other patients. I admit to having been awakened to the relevance of this particular bill for our client group fairly late in the game. Many of the comments I am going to make to you are ones the patient advocate office and other patients' rights groups have made in other forums, in particular the sex abuse task force of the college of physicians. We have made these sorts of suggestions to regulatory bodies as well.

The first point regards compliance with laws relating to informed consent to treatment and in that regard I am sure the committee is aware of other legislative initiatives by this government, many of which have been evolving over many years and many governments, but in particular Bills 108 and 109 relating to substitute decisions for incapable persons and the Consent to Treatment Act.

In public discussions to seek feedback from members of the community about this legislation, one resounding complaint was the lack of enforceability, the fact that informed consent now is more honoured in the breach among health care professionals than it is honoured in practice, and the fact that Bill 108 and Bill 109 lack any penalty or enforcement provisions that would penalize health care professionals for flagrantly disregarding the requirements, that they get the personal informed consent of a competent patient or the substitute consent of, for example, a relative of an incompetent patient.

It may be appropriate that we not overly legalize the practice of medicine and the practice of other health services. However, the experience is so universal that time and again, patients who are incapable but are acquiescing are treated without any consent at all. Patients who are vulnerable, who are inpatients in provincial psychiatric hospitals and other institutions and people with disabilities are treated without personal or substitute consent. So many of these complaints have been heard that we believe it is appropriate to have some mechanism to remind professions that it

is a requirement of the professional discharge of their particular discipline that they get the personal consent of their patients, or substitute consent where appropriate.

Just to pick from among many different sources, I note two decisions of the mental health review board, one in which the chair writes, "The doctor has taken a somewhat surprising position that although he believes the patient to be incompetent to consent to both ECT and medication, he has proceeded to administer medication to the patient," and another in which he says, "In this case, however, the board accepts the somewhat startling evidence of the doctor that staff continue their attempts to treat without valid consent for the simple reason that it is hospital policy to do so."

We have noted that despite amendments to the Mental Health Act in 1986 and 1987 that amply clarify the requirement to get informed consent, we observed in subsequent years whole wards, particularly of psychogeriatric patients, where treatment was administered without any regard to legal requirements of consent. That situation has improved now, but we believe it would be important if it is stated that it is an example of professional misconduct to flagrantly violate the requirements of informed consent.

In saying so, I am aware of the fact that the structure in the current Health Disciplines Act puts such lists of professional misconduct in the regulations rather than in the statute, and that may be an appropriate structure. I am just not terribly optimistic that the disciplines, left to their own devices, would decide to enumerate this as an example of professional misconduct, but I will leave that as an issue for your attention.

The second item I wanted to discuss concerns rules relating to the process of investigating complaints. Again, this can be a little difficult to get a handle on, but I wanted to share with you some of the frustration in cases I have been involved in. These have been confined to the college of nurses. In one case a complainant says: "The health care providers did X to me and I am aggrieved about that and I am complaining. I think what they did was illegal and violated my rights." The response from the college is that it will not refer it to discipline. They set out the allegations and say, "We've decided we weren't going to refer this to discipline," and the complainant is left in the dark: "Did the college make a finding that what I said happened did happen or did they disbelieve me? Did they believe the provider and not believe me? If they believed what I said happened did happen, did they believe it was an illegal act or not?"

For example, it could be forcibly confining an informal patient when the Mental Health Act says nothing in this act authorizes detaining or restraining an informal patient. None the less, they restrained an informal patient. The patient makes a complaint to the college of nurses. The college says, "We find no unprofessional conduct here." Well, did they agree that the restraint happened? Did they believe it happened but they do not think it was unprofessional conduct? Do they believe it is permissible for members of their profession to break the Mental Health Act? There is absolutely nothing responsive to the complaint. At the initial complaint stage, it is my understanding that there are no formal findings of fact made and yet an important decision

must be made: Should this case be referred to discipline or should it not be?

I think the situation is analogous to a police investigation. The police and the crown attorney begin a case neutrally, but in the course of investigating form an opinion about whether this is the kind of case that could stand up if it were sent to trial if a charge were laid, if that is what the colleges are meant to be doing at the complaint stage forming an opinion about the discipline likely being successful if this went to discipline; If not, then you should not waste anybody's time: if it would, then you should. If you decide not to refer it to discipline, I think you owe it to the complainant to explain to him why you decided not to refer it to discipline. The current practice does not do that.

The third item is rules relating to competence of a witness to testify at a discipline proceeding. I want to add this is a topic the committee is likely to hear a lot about from the sex abuse task force because the college of physicians' sex abuse task force deals primarily with a very difficult situation in which there is an allegation of sexual misconduct in a room with only two people, the complainant and the respondent, so often it turns on issues of credibility.

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It is particularly difficult if the complainant is someone whom our society has traditionally accorded less credibility than other Ontarians, someone who has a developmental handicap or is labelled mentally disordered or has a physical handicap that makes it difficult for him to communicate in ordinary spoken language.

I am aware of a case, again before the College of Nurses of Ontario, where a complainant said he was physically abused by staff while an inpatient in a hospital, and as a result of the proceedings, at the beginning, the health care professional who responded in the proceeding argued that the patient was not competent to testify and was successful. The consequence of that is that the patient never even had the opportunity to get on the stand and tell his story.

Some complainants will be incapable of testifying, but I think that is an improper procedure and looking at other law reform initiatives that are afoot having to do with the Criminal Code of Canada and the Canada Evidence Act, rather than have the zero sum, black and white, either you are competent or you are incompetent sort of notion, I support a policy that would permit anyone who agrees to tell the truth to get on the witness stand to tell his story. If the other side wishes to introduce evidence that their capacity to give testimony is impaired, let them introduce that evidence and the finder of fact, the committee, the judge, the board, will assign a certain weight to their testimony based on the clinical evidence of their capacity.

In the particular case I am thinking of, I was given information that had the case been allowed to proceed, another patient would testify that he was approached by a health care provider and offered a bribe to lie and corroborate the provider story rather than the complainant story. I think it is a travesty that the discipline committee never got to hear the whole tale and rather just threw it all out.

If there are very clear cases related to health discipline, if a physician leaves in a sponge during surgery, we will

have the easiest time dealing with those sorts of cases. These are the most difficult ones relating to people who are some of the largest consumers of health care services, people who are vulnerable because of mental or physical handicaps, people who are institutionalized. We have to ensure that the complaints procedure is responsive to their complaints and can accept their evidence in a mode that they are able to give.

Finally, I wanted to touch upon the duty of hospital administrators to report a physician's loss of privileges for issues relating to conduct or competence. I wanted to say, first of all, that in the code that is a part of Bill 43, section 36—I was delighted to find it there—it imposes an obligation on all people who employ regulated health professionals and obliges them to report any revocation, suspension or restriction on privileges of a member.

Another triggering event is the dissolving of a partnership or association with a member for reason of professional misconduct, incompetence or incapacity. That is good, because unlike the Public Hospitals Act which only covers public hospitals and only covers physicians, this deals with all regulated health professionals and all employers.

I contrast it with section 30 of the Public Hospitals Act. As I said, that act only covers the setting of public hospitals and only physicians, so section 86 is a welcomed addition. However, there are some other triggering events in section 30 of the Public Hospitals Act that the committee would do well to consider, for example, where the application of a physician for appointment or reappointment to a medical staff of a hospital is rejected by reason of his incompetence, negligence or misconduct.

That is another event that triggers a report to the college, the rejection of an application or reappointment or where a physician voluntarily or involuntarily resigns from a medical staff of a hospital during the course of an investigation into his competence, negligence or conduct. I think these additional events that trigger a mandatory report to the college are important and one option would be for the committee to consider their inclusion in section 86.

I anticipate section 30 will remain in the Public Hospitals Act I am aware of it because of its conspicuous absence from the Mental Hospitals Act and that is the act under which the 10 provincial psychiatric hospitals operate. There is no corresponding obligation for administrators in the 10 provincial psychiatric hospitals to report to a college a physician who is in these circumstances.

I am aware of situations—thankfully, they are rare, and I hope my comments are not taken as a witchhunt on physicians or any other health care professionals, but I am aware of cases in which the contract of a physician has not been renewed or a physician has been permitted to resign in really alarming circumstances.

I recall a circumstance in which the nursing staff approached the patient advocate to get the advocate's assistance in inquiring to find out if this person was in fact a doctor, because the nurses found this doctor's prescribing practices so bizarre. This doctor was permitted to resign and no report was made to the college of physician and surgeons. I would like to see reporting to be mandatory in those circumstances.

I will stop there to give time for questions and I anticipate the opportunity of filing something in a little more detail with the committee before the end of the month.

The Chair: Thank you very much for a very thoughtful presentation.

Mr Jackson: David, it is good to see you again. I enjoyed your presentation. There are a couple of areas and I will try and move through them quickly. Having read the Weissstut report and having difficulty reading it as any layperson would, I know we still have problems with the definition of competence in this province and that it is an unresolved matter. Is that at the root of why we are not as clearly inclusive in this bill, in your opinion? Perhaps you could share that with me because my background in this field leads me to that conclusion.

Mr Giuffrida: Is this in regard to the first issue I raised around informed consent to treatment? Whenever the law creates a distinction, there will be clear examples on either side of the line and there will be one real close to the line that everyone will struggle with. I do not think the problem I am describing can only be related to those difficult issues that are near the line.

I am looking at a report in which our advocates reviewed a psycho-geriatric ward in which there were just dozens of patients that the advocates could not carry on a conversation with. The advocates are laypeople, but they could not have a basic exchange of information. Reviewing the clinical records of these patients, they were considered by the physician to be competent in all spheres, financially competent, treatment competent. It just did not add up. I think the most cursory assessment of their capacity would have led the physician to conclude that they were incapable.

Mr Jackson: Item 4 raises some important points. Have you had any feedback from the government with respect to your proposed amendments and would you be able to table with us your suggestion in proposed amendment form?

I certainly support what you are suggesting here. In most other cases that we are dealing with, the public has a secondary recourse through the courts, but for your constituency, in almost all the cases, it is not. So there is moral pressure on us as legislators to ensure that this is the one and only opportunity for protection for these particularly vulnerable Ontarians.

I want to look very seriously at this and hopefully the committee will. I am asking you if the government has indicated in its informal discussions with you, an openness to look at those amendments?

Mr Giuffrida: I must apologize there because I have come to Bill 43 fairly late in the game and have not given the opportunity for the government to express its views. It has been very open in consulting with our program and with other people representing various consumer and survivor groups, so we look forward to discussions with them, but we have not had them yet on this issue.

Mr Hope: You have raised a number of issues dealing with vulnerable people. Will the legislation the Minister of Citizenship has introduced alleviate a lot of the problems dealing with advocacy, with what is going on with advocacy in dealing with patients?

Mr Giuffrida: We are quite excited about the prospect of the passage of advocacy legislation that will expand advocacy services to settings and to consumers who do not now have the services of advocates.

There are many pieces to the puzzle. Advocacy is necessary, but not sufficient. If a client approaches an advocate, the advocate investigates the situation and says, "The provider is doing X," but if there is no indication that what they are doing is wrong or no remedy to correct it, then it is an incomplete system.

In the provincial psychiatric hospitals, patients have had advocates from our program for eight years now. But particularly, for example, on the issue of compliance with the Mental Health Act, it is quite discouraging to report the level at which health care providers are ignoring the Mental Health Act despite the presence of advocates.

I have sat in the office of a medical director who basically said: "I don't care what the act says. I don't think it is in the best interests of my patient. I will not do it." That is despite having an advocacy program. I think they also need to hear from their peers. They need to hear from other groups, "No, you must behave according to the law."

1120

Mr J. Wilson: On your point 2 on investigating complaints, the way I read sections 24 to 27 or so—tell me if I am wrong—if someone submits a written complaint, a panel shall be struck. On your point about the panel not giving reasons if it does not take any action, I see there is a section here that says that the panel must give a copy of its reasons if the panel decided to take no action with respect to a complaint, or to do anything under the previous paragraphs. Is that satisfactory? Have you had a chance to look at that?

Mr Giuffrida: I am conscious of the fact that the concerns I am raising in item 2, may not be completely amenable to resolution in legislation. Some of it is just practice, and the college of nurses, to its credit, has begun publishing in full many of its decisions—anonimized—and it is communicated to all members. It is a very open, progressive policy. My concern is that the wording of them is not terribly responsive, and I am not quite sure how you legislate that.

What I understand to be the system is that the person within the college who does the investigating then reports back to another body which does the deciding. I am not sure why that is so. It would be, for example, as if a judge heard all the testimony of the parties and then referred the final decision to someone else who was not in the room at the time. I am not sure why that is so, why it would be wrong for the investigator to form an opinion about the possibility of success, if this were to be referred to discipline, and to share that with the complainant.

The Chair: Thank you very much for your presentation, and we will look forward to the brief you will be tabling with the committee in due course.

SHELLEY O'NEILL

The Chair: I call Shelley O'Neill. Welcome to the standing committee on social development. You have 10 minutes for your presentation, and we would ask you, if you wish to leave a few minutes for questions.

Ms O'Neill: My name is Shelley O'Neill and I am a registered nurse. I am employed in a recovery room at Women's College Hospital. I would like to thank the committee for the opportunity to discuss the Regulated Health Professions Act.

I am here today because I care about the direction in which my profession is heading and its impact on the patients I care for. Many nurses, including myself, have always referred to our certificate of competence as the licence. When I understood the full implications of being licensed, I could easily see why this profession has been forced to accept the role of handmaiden.

It is well documented that I can do 60% of what a doctor does. It does not take two sticks to rub together to see why doctors, pharmacists and dentists were originally licensed, and nurses were left to become registered. It was turf protection at its finest. So when I say to you that as a nurse I want to be licensed, why should I be any different to doctors, dentists or pharmacists, who have up to now protected and created a monopoly.

The education of a nurse is done in a very broad, general sense. We are educated to see the patient as a whole. Nurses impact on many professions and vice-versa. For example, on Saturday night I had a patient who came into recovery room after having his gall bladder removed. My biggest claim to fame in the recovery room is airway management. The act of managing respiratory therapy, as I understand it, is not listed for nursing. Airway management is the first thing that happens in recovery. The patient gets oxygen, and is usually placed on some form of monitoring. The scope of respiratory management is listed for respiratory therapists.

The act of communication is not listed for nurses in this legislation. The first thing I say to a patient is: "one, you are okay. Second, you are in recovery room and your operation is finished." I do not know if any of you have had operations, but what is the next question that comes out of your mouth? You usually ask first, "What did they do to me?" If I tell the patient that his gall bladder is out then I am helping him reach a conclusion about his diagnosis.

The act of communicating is essential in recovery room. So now the patient requires something for pain, and he has allergies to the common drugs used for analgesics. At 2 am there is no pharmacist, and I am then dispensing a medication from a night cart. At this point, it is very clear what I am performing, and I really should not be performing.

I think I have got this patient all sorted out. He is comfortable. He is informed, but he is complaining of a sore back. After two hours on a stretcher, I would have a sore back too. According to this legislation, I would see performing a back rub as interfering with the scope of practice and acts of a massage therapist.

Just to finish off, the patient's wife has gone into labour because of the stress of the situation, the nurses in obstetrics cannot find a doctor and she does not have a midwife. Now what do we do. Who is going to manage the labour?

I can go on and on, but these are everyday occurrences. I go through as a staff nurse in this province.

I have no desire to create a monopoly, and in fact appreciate the expertise of other health care professionals. As

a nurse, it is impossible to have the knowledge base of drugs a pharmacist would have, but I am certainly glad they are available to answer my questions. In terms of massage therapy, I have a limited knowledge base but the principle that massage therapy is comforting is something we can agree on wholeheartedly.

Nurses must be licensed. It is not for selfish means. Other provinces in this country have licensed their nurses, and why Ontario must remain in the dark ages is beyond me. My profession needs to be licensed. We need a legal right to define our scope of practice. As a nurse, my practice overlaps with a great many professions because I am a generalist who sees the patient as a whole.

As a nurse I diagnose, and because I am the health care provider who is there 24 hours a day, it is logical to assume I will be able to identify the needs of the patient and make arrangements for the appropriate health care provider.

In order for this profession to flourish and survive, it must be given a legal right to define its scope. The elusiveness of being a professional body is not found in higher education, but in the ability to function freely within its scope of practice. The legislation makes me feel compromised as a practising nurse, and if I cannot practise freely then the patient care in this province will be the loser.

The Chair: Thank you very much for your presentation. I have a request from Mr Wessenger to clarify on behalf of the ministry. Is that agreed by the committee? It may use up some of the time.

Mr Wessenger: Yes, I would like to have ministry staff indicate some response to this.

Ms Bohnen: Some of the speaker's concerns might be resolved by recognizing that the scopes of practice described for the other professions do not in any way detract from the scope of practice of nursing. The fact that some activities are described, such as the scope of practice of respiratory therapy, certainly does not remove it from the scope of practice of nursing, which is expressed very broadly in section 3 of the Nursing Act and it is the scope of practice that was collaborated on by nursing organizations.

Nurses have a much longer list of controlled acts than any other profession, and I guess medicine and dentistry, and those can be performed on the order of the physician, or on the order of a qualified person who may, in the circumstances to be set out in regulations, be a nurse. So within the framework of this new regulatory model, nurses have a very broad scope of practice, because as you say they are generalists and have authority to perform many controlled acts.

Mr Owens: The comment with respect to patient care suffering as a result of nurses not being licensed: I wonder if you could expand on that a little bit. I have some knowledge of hospitals, and as I have stated before the compartmentalization or specialization of medical care makes the stuff with respect to nurses a little bit more problematic. You mentioned respiratory therapists and I think Linda Bohnen just mentioned on the order of physician. Is it easy to find a doctor after 5 o'clock at a Toronto hospital?

Ms O'Neill: It is difficult to find a physician.

Mr Owens: So what do you folks do now?

Ms O'Neill: If someone comes into recovery room and I feel his breathing is compromised, what would I do first? I would put oxygen on and I would put an oxygen saturation monitor on.

Mr Owens: And then?

Ms O'Neill: That is about the extent of what I can do. At this point in time, that is what I will do.

1130

Mr Owens: You make a note of it that this is what you have done. Do you have to receive permission retroactively for the stuff that you do, and what happens if a physician or a person who is "qualified" refuses to write that order or to give you that permission? What happens then?

Ms O'Neill: I will give an example. If someone was COBD, chronic obstructive lung disease, he cannot tolerate high levels of oxygen. So if I put that on and something happens to that patient, I may not get an order from the physician to cover it, that says I have done it.

Mr Owens: Which puts you in jeopardy in terms of your licence to practise or your certificate.

Ms O'Neill: It is a certificate of competence; it is not a licence.

Mr Wessenger: I think we need further clarification.

Ms Bohnen: The real world, of course, of how hospitals currently operate is that—

Ms O'Neill: I know the real world.

Ms Bohnen: —there are many standing orders in hospital protocol—

Ms O'Neill: Not ours.

Ms Bohnen: —that permit staff to operate when somebody who is authorized to prescribe or authorize some other invasive activity to take place is not present. That is, in the ministry's view and in the government's view, exactly how they will continue to operate.

Ms O'Neill: Has the ministry ever been in the situation where it has had to accept standing orders? You make an assumption about standing orders and you have no idea of reality.

Mr Owens: If I could pose this question on the record to deal with at the end of the day with the ministry, does the ministry follow up with hospitals to ensure that standing orders are in place, whether they are appropriate, how they are utilized, if they are utilized? I think that is very important, especially with the changes coming to the nursing profession. I think you make a good point that what is on paper is not necessarily what is happening in the field. I would like to know with respect to quality assurance what is going on in the field.

The Chair: The question is noted and on the record. Thank you very much for your presentation.

Mr J. Wilson: I have a couple of questions for the ministry. First, I would like an explanation at some point today, I suppose, of the difference between licensed and registered for nurses. I have a concept of both in my mind, but I am not sure it is what the legal definition would be. Second, I was wondering whether in the College of Physicians and

Surgeons of Ontario authority they are allowed to delegate controlled acts to nurses.

JIM FRASER

The Chair: Jim Fraser, welcome to the standing committee on social development. You have 10 minutes for your presentation. We would ask that you leave some time for questions from the committee.

Mr Fraser: Good morning, my name is Jim Fraser. I am a registered nurse practising in the province of Ontario and I am employed at the Toronto General Hospital in the operating room. I am pleased to be here to address some concerns about the Nursing Act with specifics about accountability of nurses.

I would like to thank the various Health ministers and their staff for the lengthy hours they put into preparing this legislation and for the opportunity to have input into the process.

At the onset, as a nurse I must say I was disappointed with the legislation. I had hoped and expected that my role as a registered nurse would be licensed and that my experience and skills would be more efficiently and effectively used by allowing me to do more controlled acts independently.

I believe the legislation neglects to recognize me as a nurse, but most importantly as an autonomous member of the health care team. The legislation puts me in a difficult position to be able to deliver the best possible health care to our patients. The legislation makes it extremely difficult for me to remain a patient advocate when I could be disciplined, fined or imprisoned if I act without an order of a qualified person.

Currently nurses must exercise their judgement in determining whether to carry out treatment ordered for patients and are accountable for exercising suitable judgement. Nurses have been found guilty of negligence for carrying out inappropriate orders. The proposed legislation would enable other governing bodies that have control under the acts to investigate. I have great concerns about this. I could be found not guilty by the College of Nurses of Ontario and by the College of Physicians and Surgeons of Ontario, but still could be prosecuted in a court of law.

I strongly believe that the college of nurses has the necessary knowledge to determine whether a nurse has met the appropriate standards of practice, and therefore the college of nurses should be the only governing body able to investigate complaints about its members.

The government, by amending the Public Hospitals Act to allow registered nurses to be part of hospital decision-making committees, began to recognize the knowledge, expertise and accountability that nurses provide to the citizens of this province. The proposed legislation does not allow nurses to perform any controlled acts independently. I feel this has turned back the hands of time, putting nurses in the handmaidens' role again, only being able to act on the order of a qualified person. Nurses have proven themselves to be competent, qualified and accountable practitioners. If nurses were legislated more independence, duplication of services could be decreased, resulting in a more cost-effective and efficient system of health care.

I also expected, to protect the public fully, that all registered nurses would become totally accountable under the legislation and to their governing body. By "all registered nurses," I mean staff nurses, nurses who are administrators, nursing management, teachers and researchers. It is worth noting that the Canadian Nurses Association has recognized this need by establishing its own standards for nurses who are administrators, educators and researchers. I have attached that as appendix 1.

It is crucial for these nurses to become accountable to their governing body in order for the public to be fully protected. Nursing administration and nursing management are so far removed from the bedside and direct patient care that they may not be making best use of the resources and their decisions may jeopardize the quality of care our patients deserve.

To give you an example, I work in an operating room. When I am working evenings, nights or weekends and the OR is quiet, I have been told by the nursing supervisor that I must go to relieve in recovery room while one of the two recovery room nurses goes to relieve in one of the intensive care units. I make my objection well known to the nursing supervisor that I am not qualified to work in recovery room, which I am required to do by my governing body, the College of Nurses of Ontario. Working for a unionized employer, I have the right to file a professional responsibility complaint or to file a grievance, but in both incidents I must obey and take action following the incident. But most importantly, by placing me in recovery room it has removed me from my specialty and has placed the patient in recovery room in a less than desirable care situation.

My scope of practice for the past five years has been in the operating room, for which I have a post-graduate certificate. All nursing units function under the minimum standards of nursing practice with required expanded roles for their unit certified under "Added Nursing Skills" as set out by the college of nurses and "Sanctioned Medical Acts" as set out by the college of physicians and surgeons. By being put in a highly skilled area such as the recovery room, I am not certified to perform any of their sanctioned acts or added nursing skills, therefore placing more of a burden on the only nurse capable of performing such duties which results in increased risk of harm to patients and decrease in the quality of care the patients deserve, that their tax dollars pay for, and the high quality of care they have enjoyed in this province.

To cite a further example, if the nursing manager of a cardiology floor does not staff the unit appropriately: There are 24 patients, four of which are on cardiac monitoring. Two registered nurses are ill for the night shift, leaving one registered nurse and two registered nursing assistants to cover the floor for a 12-hour night shift. The nursing manager calls some of her casual staff, but no one can come in, so she calls the evening administrator-supervisor and asks her to staff for the floor. The supervisor says she will do her best.

The nurse coming in at 1915 hours is told by the shift going off that the nurse manager has made arrangement with the evening supervisor for staff to come in and help on the floor. The floor is sent a new graduate nurse, not yet registered, and a registered nursing assistant for the shift.

The RN on the floor immediately calls the supervisor and tells her that this is unacceptable because she is the only qualified RN with monitoring skills and cannot leave the monitors unattended. The new graduate nurse cannot carry narcotic keys or give all medications necessary to the patients on the floor, such as intravenous narcotics, some intravenous medications that you have to be a registered nurse and certified to give. The cardiology nurse has to respond to all cardiac arrests in the hospital for the night shift, and that is impossible because of the inappropriate staffing of the floor.

The RNAs are limited by their educational background, therefore limiting their scope of practice. They can provide basic care only to patients and will not risk their registration by performing skills outside their scope of practice. The patients in this situation, because of inappropriate staffing, have had their lives put in jeopardy, but also the RN in charge of the floor has had her registration with the college of nurses put in jeopardy because she is the only one in this situation who is totally accountable to the college of nurses, because currently nursing administrators, management, educators and researchers are not accountable to the college. I refer you to appendices 2 through 5.

In closing, I would like to urge the committee to review my concerns and added appendices. I strongly believe that all professions should be licensed with definite scopes of practice, therefore ensuring accountability of their members; that registered nurses who are administrators, educators and researchers should be included in the legislation to ensure that they become accountable in order to protect the public; that the legislation should be amended to enable registered nurses to perform designated controlled acts independently; and that nurses remain the patient advocate to ensure patients receive the high quality of care they deserve as citizens in Ontario.

1140

Mr J. Wilson: Thank you very much for this excellent presentation, and in particular the description of a night on the hospital ward. I was wondering if you could help me in trying to understand the difference between licensing and registration. The sense I am getting on licensing is that if the nurses were licensed, the college would be able to define, really, its own scope of practice. Is that your understanding?

Mr Fraser: Yes. By being able to define their own scope of practice, hopefully with licensing we would be able to bring nurse administrators, educators and researchers in and make them totally accountable.

Mr Wessinger: I think I would like to have that clarified for the committee.

Ms Bohnen: Under current legislation some professions have a licence to practice. That means that only members of the profession can perform any function included within the scope of practice, such as medicine. Other professions are registered professions or certified professions. Nursing is currently a registered profession because nursing does not have an exclusive scope of practice, such as medicine. Other professions are registered professions or certified professions. Nursing is currently a registered profession because nursing does not have an

exclusive scope of practice, but nurses have the benefit of exclusive use of the title RN, registered nurse.

This legislation abolishes the distinction between a licensed profession and a registered profession, because there are many problems with maintaining a system based on that distinction. But even if you had a system in which professions were still licensed, the profession would not control its scope of practice. The Legislature controls its scope of practice by writing in the Nursing Act or the Medicine Act what the scope of practice of the profession is. Under this new system, every profession has a described scope of practice. The controlled acts then go on to list which hazardous activities are restricted to members of the various professions. So we have really done away with that distinction between licensing and registration.

Mr J. Wilson: Thank you; that is helpful. I had a similar discussion with nurses yesterday on that. Given that we have gone to this model, the scope of practice model, and I do not think the government is going to change its mind and go back to licensing—this is what I told nurses yesterday, for instance—would you be satisfied if we tried to accept some of the amendments that have been brought to us by the union, for instance, in expanding the scope of practice for nurses? I think that is the only remedy we can come up with as a committee. Would you be prepared to come back to us with some suggestions on where you feel you are not being given authority now and should be given authority, given that you have given us a very good example of what it is like on a ward?

Mr Fraser: Yes, I would be willing to come back with amendments.

The Chair: Let me clarify for you that all future correspondence would be in writing. When Mr Wilson asked if you will come back, it is by writing and communicating with the committee your thoughts and ideas as the hearings progress.

BRUCE CAIRNIE

The Chair: I would like to call now Bruce Cairnie. You have 10 minutes for your presentation and we would ask that you leave a few minutes for questions from the committee at the end. If you could begin now, we would appreciate it.

Mr Cairnie: I am very pleased to be able to be here with you today and to present to you my feelings about the Regulated Health Professions Act as a Presbyterian minister and also as a concerned member of the community.

I feel basically that the health professions act has a sound beginning and a good thrust at its introduction, but I have a concern about the way it will affect the ministry I carry out in the community in which I live, and the way it will also affect all other ministers in the province. We routinely find ourselves in situations where people ascribe a great deal of trust to the things we say. That is the nature of our function. Routinely people, when they are unwell, come to us and ask: "What is wrong with me? Why am I feeling this way?" We routinely respond and could be committing what might be called a controlled act, because seeing symptoms in a person, we respond with our assess-

ment of what that might reveal in that person. We cannot diagnose diseases, but the definitions of disorders and dysfunctions are such that many things we deal with are covered. I would like to explain three situations and show you specifically how they affect people's health.

As a minister I work regularly with people who grieve. Customarily we think of grief in terms of bereavement, but it is also a common response to any sense of loss: a loss of work, of friends, of a marital partner, of a community through a move to another area. All of us grieve in different ways, but there are some common signs of grief that arise. They can be loss of appetite, loss of sexual desire, restlessness, insomnia, all sorts of different things like that, things for which we would customarily consult our doctors. But as I am told of such a thing by a person who is grieving, it is responsible for me as their pastor to see if there is some connection between their loss and the symptoms they are displaying. As I talk with them, those things, those connections, come to light.

For example, a woman who was bereaved came and said to me, "I'm feeling like I'm getting ill now." We began to talk about what it meant that her husband, to whom she had been married for many years, had died and she was suddenly alone. It was her loneliness and her sense of empathy with his sickness that she was beginning to discover in her body which was affecting her health. But as we talked, she found that those symptoms began to lessen and disappear. It would be irresponsible for me to say, "You should not go and see your doctor," because the person could be genuinely ill, but at the same time, if we veil the symptoms that arise with antibiotics or other medications or even just sleeping pills, the real healing that the person needs in responding to his loss cannot happen. That is a concern I have.

Who but the minister, I wonder, in the community in which I live especially, a town of about 2,000 people, is capable of dealing with grieving people? Our services are not duplicated in the town where I live.

The second situation deals with the problem of guilt. Some people find themselves burdened with an overpowering sense of guilt and can find it affects their health through the stress and anxiety that it contributes to their lifestyle. Again they might come to me. I do not even mean here just people who are members of the two congregations I serve, but people in the broad community. They could come and want to talk. I cannot turn away from them, but instead I propose that we talk of forgiveness and of how God's forgiveness in particular can affect them body and soul. As the person receives forgiveness in time, when he is able to do that, he might be freed from the anxiety and stress and the wear and tear it puts on his physical health. It is a day-to-day problem for many people, guilt, whether it is real or perceived, and they need to deal with it. It can affect their health, but it is a condition primarily of the soul and it demands the attention of a pastor far more than a doctor.

A third situation is one which might arise more in my community service on a broad scale. It is very normal for me to be invited into homes when I do not know the people at all, or to speak with people as I walk past them on the street. It is not unrealistic at all to envision myself

being in a situation where I can easily observe evidence of overdrinking. It could be just after lunch and already the person is smelling very strongly of alcohol. As a person who is commissioned by the church to care for the members of that church and the whole community, it is responsible for me to investigate as I can and observe this person to see if he really does have a problem with his drinking and then, making a conclusion, suggest to him, if I think there is a problem, that he deal with it through Alcoholics Anonymous or some other channel.

In doing that I would be anxious, if this legislation were passed, that I could be found guilty of doing something wrong simply in looking out for the better interests of an individual and the community, because I would have made a diagnosis and communicated it to a person.

All of these are routine situations that ministers encounter. They are not things that are fanciful. My colleagues and I encounter them all the time. But if we were to overlook them, I sincerely believe we would be abandoning the posts we are called to as pastors.

I also have a secondary concern which is purely a practical one. In the small town where I live, none of these services are duplicated. They are available maybe 40 minutes away, but people are not so likely to drive that far. They need them in their area, and the clergy are the one group of people in town who are able to offer this.

In proposing the diagnosis clause in the act, I believe the protection of Ontario's population, which is a valid concern, is being taken too far. I fully agree people must receive only genuine health care, but I maintain the pastor's work is part of that. No responsible person works beyond the level of his competence or outside his expertise. I do not diagnose diseases, but I can work in diagnosing disorders and dysfunctions. I am competent to do that.

Surely this work is part of the constructive and desirable role the clergy play within the community. Theologically I view it as part of the work we do in establishing God's kingdom, a place where wholeness and reconciliation are achieved. Today we are charged with working towards that, and so by backing away from what might be determined as controlled acts, I back away from something to which God has called me. That is where the crisis of conscience arises for myself and other ministers. Do we step back and obey the government we have elected and let our communities down, or do we go ahead with something that is a proper part of our caring presence?

It is a complex question, but I believe my answer is simple. I must obey the higher authority. With all due respect to my government, I must obey God, who has given me a particular role. I cannot step out of the role He has given me.

I appeal to the standing committee on social development to recognize the predicament in which the clergy of Ontario will find themselves should this legislation be passed with its current wording. We will find that we are at risk before the law for fulfilling the function we serve properly as caring people in the community.

1150

Mr Hope: These are some of the concerns I brought up at the beginning of the hearings. I think it is important that

the ministry address some of the concerns this individual has put forward dealing with some of the issues I talked about. I think some clarity needs to be brought across.

Ms Bohnen: I believe this is the first speaker who is a member of the clergy who has addressed the committee so far. You have heard the clerical aspect of the problem in the controlled acts dealing with diagnosis, and in distinguishing between those diagnostic communications that only certain care givers like physicians should be able to provide and all of those other communications that the clergy must be able to continue to provide—the counselling services that are necessary and must be protected. In the end, I think that after hearing all of these concerns, you will then be in a position to suggest possible changes to the wording so that activities such as counselling provided by the clergy can be protected.

Mr Hope: I guess the concern you have dealing with the language in itself is “diagnose,” or is it “disorder” and “dysfunction”? Is it all three or just two of the three?

Mr Cairnie: All three. Plus, in the role I play, I am in a circumstance where people perceptibly rely on what I say. That is the other part of the introduction. I think it is section 26 that says—I could do it in the circumstance where people do not rely on what I say, it sounds like, but if they do rely, I could be in trouble. It is impossible for me to step out of that situation.

Mr Beer: I guess what is difficult with this, in relation to yourself, is that one can think of other people, teachers for example, who may also at times be in that kind of situation. In terms of the kind of exemption, you will recall there was a discussion of a harm clause. Do you have a definite view as to how to handle this, or just simply that it needs to be clarified?

Mr Cairnie: I am not sure I have a specific solution. I am torn between appealing for an explicit exemption for clergy and recognizing the concerns that other groups have. The reason I am torn is because I feel there are two different sources of authority we are functioning under. I function with a spiritual authority, whereas other groups may function with a societal authority. That is where my indecision arises. I would like to ask for an exemption, but in sympathy to the other groups, I am not altogether willing to say that is what I want.

Mr Beer: As long as what is achieved is that you do not have to be concerned about it.

Mr Cairnie: Yes, as long as what is achieved—and that might sound selfish—but that is my big concern, that I am allowed to function without any anxiety before the law.

The Chair: Thank you very much for your presentation. We appreciate your coming before us today.

SANDRA LECCE

The Chair: I call Sandra Lecce. We have 10 minutes for your presentation and we ask that you leave a few minutes, if you will, for questions from the committee at the end.

Ms Lecce: My name is Sandra Lecce and I am a general staff nurse at a 300-bed community hospital in north-west Toronto. I am pleased to have the opportunity to

address my concerns regarding this proposed legislation, the Regulated Health Professions Act.

After reading the proposed legislation, I was disappointed and dismayed. Instead of an expanded role for nurses, we once again find ourselves not being recognized as an equal and participating member of the health care team.

I understand that the intent of the legislation is to protect the public from unqualified, incompetent and unfit health care providers. In order to accomplish this, the legislation must enable nurses to practise safely and efficiently.

Under the proposed legislation, “The practice of nursing is the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function.”

Under the existing Health Disciplines Act nursing is not licensed and there is no defined scope of practice. Now, instead of licensing any professions, acts will be licensed and these are called controlled acts.

Any member of the public can assess, provide care and treat health conditions as long as they do not call themselves nurses. Anyone, according to this proposal, can administer an oral medication. Does this mean that the camps in Ontario that currently employ nurses will not need to hire nurses next season? Will they simply hire a member of the public to treat their campers and save on the salary they would normally pay to the nurse? Will this legislation affect the camping association standards?

There are 13 controlled acts listed in the legislation, only three of which nurses would be authorized to perform while engaging in the practice of nursing. The committee is well aware of the 13 controlled acts. Nurses are authorized to perform the following while engaging in the practice of nursing: the second controlled act, “performing a prescribed procedure below the dermis or a mucous membrane on the order of a qualified person.”

Nurses in the home sector, who often only have doctors visit once a week, will not be able to treat a bedsore. I know that when my grandmother fell and broke her hip and was eventually confined to the infirmary of a nursing home, it was the nurses who diagnosed and treated any bedsores. When she developed mouth cankers, it was the nurses who initiated the salt water gargles and mouth swabs that helped to cure them. Would the same be true under this legislation?

“Administering a substance by injection or inhalation” is number five. The emergency department at the institution where I work can be very busy. It is a common occurrence to be dealing with two or three urgent situations simultaneously. Does this mean that if the doctor is busy treating a cardiac arrest, a child who comes into the emergency department in the middle of an asthma attack cannot even receive oxygen because the physician is too busy to see the child and order it? If the nurse administers it without an order, is she facing a fine or imprisonment? If she does not administer it and the patient does poorly and suffers damage as a result, will she face a lawsuit?

At the hospital where I am employed we also have a critical care nursery. Can the nurse administer oxygen to a baby in distress? If it takes 15 to 30 minutes to get a response from the doctor, this could do irreparable harm to the infant.

Does this act include ongoing parenteral infusions, such as IV solutions, blood or blood products, medication through peripheral, central and arterial lines? It is not clear in the act. As an IV nurse, this concerns me. I believe these acts should be controlled. At the present time, we must be certified for these acts.

Will the radiology technician inject dye in the X-ray department? Does he or she know the difference between a dye allergy and an insulin reaction? Will I be restarting more IVs because the line has run dry and become occluded in the X-ray department?

Number six is "putting an instrument, hand or finger"—on the order of a qualified person—“(i) beyond the external ear canal, (ii) beyond the opening of the nostrils, (iii) beyond the larynx, (iv) beyond the opening of the urethra, (v) beyond the labia majora, (vi) beyond the anal verge, or (vii) into an artificial opening into the body.”

If the ICU doctor has not yet written orders on a fresh tracheotomy patient or a newly intubated patient, the ICU nurse will not be able to suction. These nurses who defibrillate and administer lifesaving agents in life-threatening situations must now request an order for an aspirin or a suppository. At the same time, according to this proposal, any member of the public can administer oral medication. It is not a controlled act.

Controlled act number one involves communicating a conclusion identifying a disease, disorder or dysfunction. This is not a controlled act for nurses. Until recently, nurses in our day surgery unit routinely obtained consents and in our outpatient department, chemo clinic and radiology nurses are still obtaining the consents. If we cannot discuss it, how can we ensure that the consent obtained is informed? Even in cases where the doctor obtains a consent, it is still necessary to ensure that the patient understands the procedure.

When I worked in the OR, I once had a patient who was to undergo a bowel resection with colostomy. Upon talking to the patient, I realized that he did not understand what a colostomy was. Under this legislation I would not be able to discuss this any further with the patient. I would have to go searching for the doctor to explain the procedure to the patient again, all the while putting up with his glares and sighs, and then I would have to endure an earful about not doing it myself and dragging him away from something important.

Number eight is prescribing and dispensing medication. In my hospital, the pharmacy is open from 8 until 5. Will the hospital have to hire another pharmacist for off hours? If so and he is on call, will the patients have to wait up to an hour for the necessary medication? Can the staff nurse on the floor no longer give medication from the stock cupboard without every RN being certified?

Number 12 is managing labour and conducting the delivery of a baby. Nurses are presently involved in various aspects of labour and delivery and in many cases are the only health care givers present until the actual birth. Many experienced obstetrical nurses can manage labour and deliver babies better than most doctors.

Four years ago I was present at the labour and delivery of my godchild. Labour progressed very quickly and my goddaughter arrived before either the obstetrician or the

anaesthetist. She not only arrived safely, but her mother did not even suffer any perineal tearing. If it were to happen under this new legislation, would the nurse simply have to watch? For the sake of the unborn children, I certainly hope not.

What happens to exercising reasonable knowledge and skill and care criteria? What happens to standing orders? All of the controlled acts are to be done on the order of a qualified person. How many qualified persons will be writing orders on the same patients? It will be the nurse who is left holding the bag.

Many nurses have been forced to work in situations where they are understaffed. I would like to look at the following hypothetical situation.

I am short-staffed and not able to give the required care to Mrs Jones. Mrs Jones's family reports the incident to the college and my practice is investigated. At the end of the process, I am found guilty of incompetency and my registration has a restriction placed on it. The family also reported the head nurse, the co-ordinator and the VP of nursing, as they did not provide an adequate staffing complement. Their registrations are restricted, but they appeal the college decision. On review, the courts decide that the college has no jurisdiction over the head nurse, co-ordinator or VP of nursing because they do not give direct care.

The definition of "practice of nursing" in the proposal does not include the components of administration, education and research. Judicial review under the present Health Disciplines Act has been found time and time again to apply only to those giving direct patient care. Administrators, educators and researchers in nursing are not accountable to the college; only those giving direct patient care are accountable.

This legislation does nothing for the nurses to relieve my profession from the triple jeopardy we find ourselves in while engaging in the practice of nursing. I am accountable to my patient. I am accountable to the college of nurses to maintain the standards of nursing practice. I am accountable to my employer. The employer must share the accountability for what a nurse does or does not do as a result of insufficient staff or budget.

In conclusion, I would ask you to consider that, all professions should be licensed to practise with a defined and specific scope of practice, that researchers, educators and administrators should be accountable for their practice, and that the RHPA does not protect the public.

Health care will become more fragmented. Nursing is the only profession that looks at a patient as a physical, mental and spiritual being, as a whole person. Nurses are with the patient 24 hours a day, 7 days a week, not 9 to 5, Monday to Friday, and we are the hands-on practitioners. I love my profession and I deliberately chose it. I have worked as a nurse full-time for 17 years. I wish to contribute more, not less, to the care of my patients.

The Chair: The committee very much appreciates your presentation and I know will take it into consideration during its deliberations. The committee now stands adjourned until 2 this afternoon.

The committee recessed at 1205.

AFTERNOON SITTING

The committee resumed at 1404.

ROYAL COLLEGE OF DENTAL SURGEONS
OF ONTARIO

The Chair: The standing committee on social development is now in session. I call on the Royal College of Dental Surgeons of Ontario. Begin your presentation by introducing yourselves and leave a few minutes at the end for questions from members of the committee. You have 20 minutes for your presentation.

Dr Beyers: My name is Dr Beyers, and I am the president of the Royal College of Dental Surgeons. Mr Bromstein is our legal counsel and Dr Dunn is formerly a registrar of the college. Dr Dunn is also the founding dean of the dental school at the University of Western Ontario and the immediate past-president of the Royal College of Dental Surgeons. He will begin our presentation.

Dr Dunn: The royal college is most appreciative of this opportunity of presenting a few highlights from its submission which we have left with you today.

The royal college is the governing body of the dental profession in Ontario. We are not entirely lacking in experience because at the first session of the first Legislature in 1868, the college was formed by the Dentistry Act of Ontario. Appearances to the contrary, I was not around at that time, but it has been functioning fairly well since that period.

I would like to say too that the college has worked harmoniously and co-operatively, both with the review during the developmental stages of this and with the ministry, particularly the professional relations branch, since the report was presented.

The history of this legislation, in my view, is probably unique in the sense that it was established, first of all, through the efforts of the then Progressive Conservative government. The report then was presented to a Liberal government in which Bill 178 eventuated with your distinguished name attached to that, Madam Chair, and then subsequent to that, Bill 43, which is now under discussion, plus the associated acts. I have to say that when one reviews 178 in juxtaposition to 43, there are only something in the order of 37 or 38 amendments, none of which, in my judgement, is a substantive one.

We are not so naïve as an organization as to think this is a statute that is going to be terribly volatile, because there is already a pretty reasonable consensus in terms of the approach that is being taken.

Because the legislation which is proposed in this bill is, again to the best of my knowledge, unique in the entire world—we know of no other jurisdiction anywhere which approaches the governance of health professions exactly on the basis of Bill 43—therefore, we urge upon you, because we have only a very brief time, to read the submission which we have offered. We think we have done this responsibly. We are speaking on behalf of the college, and we recognize absolutely, unequivocally, that our role is one that must serve the public interest and conscientiously we have attempted to do that.

It is no secret that we are concerned about the controlled act concept. We are particularly concerned about the fact that the statute or the bill does not appear, at least to us at this moment, to deal effectively with the prosecution of illegal practice, that is practice which is inimical to the welfare of the public.

You may recall that in the review report section 27.04 was proposed which was to address itself to the enforcement; prosecution, if you like. That was eliminated in Bill 178 and it still continues not to be present in Bill 43. Although we had some problems with 27.04, I would again have to remind you that in December 1989 the Ministry of the Attorney General, through the crown law office, having been requested to present an opinion in this regard, said that it was vital that there be something akin to 27.04, but the crown law office did indicate that 27.04 did not do it.

We have proposed in appendix A a possible substitution for 27.04 and we would direct that to your attention because we think, and we agree with the crown law office, that this is absolutely vital to a consideration of this issue.

We are concerned also about the issue of diagnosis. We recognize that this has been somewhat controversial. We are a little bit concerned this is not simply a communicating of a conclusion and that sort of thing, but I have to tell you that diagnosis is absolutely central to what dentists do to pursue the treatment of a wide variety of treatment requirements. Without having previously done an effective diagnosis in our judgement would be totally irresponsible professionally. So we are simply saying that we believe that diagnosis is fundamental and that it should be retained as a controlled act.

1410

In respect of controlled acts for dentists we have two observations. It comes as no surprise that dentists perform services on teeth and yet we can find nothing in the controlled acts which deal with this. And there are a wide variety of activities such as pit and fissure sealants and the like which we believe really need to be addressed. We are recommending an additional controlled act of performing procedures that alter the surfaces of teeth and we would ask you most objectively to give some consideration to that.

Also I have to advise you that dentists do use various forms of energy to perform procedures within the oral/facial complex: lasers for cutting both hard and soft tissues, cauteries, electric stimuli for pain control, electrical pulp testing and the rest of it are all procedures which dentists perform. And we note that for physicians there is an authorizing act applying or ordering the application of prescribed forms of energy and we believe that this should apply as well to dentists and therefore that would need to be tidied up in Bill 49 as well.

We are concerned about the controlled act as far as denturists are concerned. Denturists currently are legally permitted to fit and dispense full and upper and lower dentures, and under the supervision of a licensed dentist, are able as well as to deal with partial dentures; and these are prostheses that utilize the patient's own natural teeth

for retention in the replacing of one or more missing teeth. And to perform removable partial denture service properly, a clinical and X-ray examination of the adjacent teeth and soft tissues in our view is essential.

It is necessary too that the supporting teeth be prepared by cutting or grinding and not infrequently built up by a restoration of some kind in order to provide a path of insertion for the removable partial denture and for its retention and support and for a proper bite to be achieved between the upper and lower jaws. Such needed changes are irreversible and soft tissues too frequently require attention or surgical alteration. And inasmuch as the controlled acts for denturists does not differentiate between full dentures and partial dentures, we believe that such a fundamental departure is totally inappropriate in the absence of technical submissions to be carefully and conscientiously considered.

The bill as you know provides for an advisory council. If you look at subsection 11(c) you will find that the advisory council does have an opportunity to consider these, and we would strongly urge that the status quo be maintained until such time as the advisory council can receive technical submissions and deal with the issue at that time.

I think it is fair to say too that we have a modest concern with the powers of the minister. While we are quite confident that current ministers and past ministers are not going to exercise powers unreasonably, the fact is that the statute in effect says that the minister has the power to do absolutely anything which a council of the college has, and if you extend that to its, maybe, unreasonable limits: the power to appoint a registrar, the power to buy and sell property, the power to send things to discipline. And it just seems to us that given the fact that slightly less than 50% of the council will be appointed by the Lieutenant Governor in Council, considering the fact that the regulations are only regulations when approved by the Lieutenant Governor in Council, considering the fact that any bylaws must at least be filed with the ministry, at which time presumably observations and comments can be made, we think that expense of power is something that is inimical to the self-governing concept which we understand this entire report has been based upon.

We have made recommendations in our submission in respect of manner of publications of discipline hearings. What we are indicating in this is that there should be some flexibility so that these issues can be brought to the attention of the profession without the necessity of having them lodged only in annual reports. The publication of members' names is another concern of ours. There are certain instances our discipline committee could tell you about in which we have been advised strongly by psychiatrists that if certain names had been published at a certain time, the results could have been extraordinarily serious.

We are concerned about the way the statute talks about referral of complaints to the discipline committee. We believe as currently worded the public is being better served, rather than the wording that now applies, and we have made observations in respect of that.

The power of the registrar to investigate is another area that concerns us, because when that happens usually it is

necessary for some immediate action to be taken on the part of the registrar because of some serious difficulty. The current bill requires the registrar to get the approval of the executive committee, about five people, sometimes very, very difficult to get together in a short time. We are recommending that the registrar, if you feel this is necessary, could be any one of the president or the vice-president or the executive committee.

The sexual misconduct in terms of witnesses: We totally support the view that the identity of that person should be maintained, but we also suggest that in the event the charge being brought against the individual is not a valid one, the same should apply to the individual against whom the charge is being laid. On a finding of guilty of course it could be published anywhere.

The final comment I want to make is simply that we strongly support the governing board of dental technicians in respect of a controlled act for dental technology. I cannot overstate the importance of the registered dental technician in terms of the quality of prosthetic services dentists perform. I think it is essential that somehow or other the services technicians render can be recognized by some controlled act. That, Madam Chair, is a very brief summary and we would attempt to respond to any questions which you or the members of the committee would pose.

Mr J. Wilson: Thank you for the presentation. You have given us a lot to think about, but on powers of the minister you do make a good point, that it does seem rather strange that the minister would have the same powers as the council. It does seem to cut into the self-regulating principle. Can you give us any practical examples where you could see a conflict there?

Dr Dunn: I mentioned two or three things. We cannot even imagine the minister determining who the registrar is going to be, our chief administrative officer. We would be concerned that, for the referral to discipline, which is an extraordinarily important area, there be good checks and balances in that system to make sure we are acting appropriately.

If the minister has the total power of the council, the minister unasked, uninvited could indeed do this. All I am saying is that anything the council can do according to the way it is written could also be done by the minister. As you said, I do not think that reflects what self-governance is all about. We do not mind the checks and balances in terms of regulations, and even the minister can require the council, giving it 60 days, to enact regulations in certain areas. We have no problem with that one either, but we have problems with this one.

Mr J. Wilson: Except that it gives you 60 days and if you do not, then the Lieutenant Governor in Council does it anyway.

Dr Dunn: That is true.

1420

Mr Beer: I would like to pursue the question around the denturists. The other day as well, I believe, a representative from the dental schools was in and made the same point. I just want to make sure I understand clearly what is at stake in this case. Basically, you want to ensure that a denturist performing or preparing a partial denture would

be done under the guidance or direction of a dentist. Can you just explain a little more clearly? The present provision allows them to dispense partial dentures, is that correct?

Dr Dunn: No. Partial dentures under the supervision of a dentist. With full dentures, of course, they are totally, legally within their jurisdiction to do that.

Mr Beer: All right. What is the key thing, in the view of the Royal College of Dental Surgeons of Ontario, that they cannot do or why they are not able to do the partial, what element of training or education? Why does that have to come into play here? I gather it was Alan Schwartz who recommended that change at the end of his review, and we are going to be meeting with him later. I just want to make sure I understand because it is the one place where there has been a change in the scope of practice.

Dr Dunn: Perhaps a practising dentist could deal with that.

Dr Beyers: My understanding at the present time is that the training of denturists does not qualify them to attend to natural teeth and also the supporting structures of the natural teeth, the bone support and the gums which surround these teeth. From a practising dentist's point of view, you have to understand that the patients within my practice who currently wear partial dentures I would classify loosely as my critical-care patients, in the sense that they need more detailed and more careful attention, if you will, in order that the partial denture does not have an effect of causing deterioration to the natural dentition and to the surrounding bone and gums.

Mr Beer: What would your role be, then, in working with a denturist? How would that work? Would they send a patient to you or would this be a denturist working directly with you if they were to do a partial denture?

Dr Beyers: In current legal practice in Ontario there are some denturists who have a joint practice relationship with dentists. The dentists do the diagnosis and evaluation and tend to natural teeth and supporting structures and then the therapist or the denturist performs the impressions and the mechanical work to deliver that partial denture.

There is a strong need for the public to understand how important it is to maintain those natural teeth. There is a very common clinical entity out there where a member of the public is wearing a full upper denture and could use a partial lower denture. If they seek the services of a denturist without seeing a dentist first to get this partial lower denture, they may assume that all of their needs are being met and that they are receiving safe treatment. The fact of the matter is that these natural teeth are not being addressed within the isolated practice of a denturist.

Mr Owens: In terms of your submission with respect to the publications of member's names after being disciplined, what would you recommend as a check the public could count on if the college decides not to publish a practitioner's name? In the area of sexual assault or sexual misconduct, I think there is a fine balancing act we are following here: the right of the public to know that this dental practitioner is guilty of sexual assault.

Mr Bromstein: I think the college is looking for some flexibility where, during a hearing—and it is usually during the penalty portion of the hearing—there is clear evidence under oath given by experts testifying to the fact that the publication of the member's name would cause certain irrevocable harm. In the instance that Dr Dunn was referring to, we actually had two experts testify that it would likely result in the suicide of an individual.

To bind them to publish, if they provide for suspension, for example, would effectively put them between providing a suspension, which might be the proper penalty, but then requiring the publication of the name or providing for some lesser penalty in order to avoid the publication and the possible result of harm to the individual. They are just looking for some flexibility in those very unusual circumstances. The suggestion the college made was that there be a power to exempt in circumstances where the discipline committee is satisfied, based on the evidence, that the publication of the name would result in significant physical and mental harm. We tried to clarify—it is legal language—to provide some suggestion to the committee in that regard.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today. All members have received a copy of your brief.

ONTARIO DENTAL HYGIENISTS' ASSOCIATION

The Chair: I call on the Ontario Dental Hygienists' Association. Please come to the table. Start your presentation by introducing yourselves. All have received a copy of your presentation. You have 20 minutes. We would ask that you leave a couple of minutes at the end for questions from members of the committee if you wish. Please begin now.

Ms Dempster: I would like to begin this presentation by introducing the members sitting at this table: Margaret Walsh and Carole Ono, and my name is Laura Dempster. Collectively we represent various factions of dental hygiene, including public health, education and clinical practice. We are all members of the ODHA's steering committee for the College of Dental Hygienists of Ontario, of which I am the chair.

I would like to take this opportunity to thank you, Madam Chair, and the committee for giving us the opportunity to give this presentation and let you know that we will be addressing the key points that we feel are necessary and are drawn out in our brief. I would like to say at this time as well that the ODHA continues to be supportive of the proposed health legislation, and we certainly look forward to a new, innovative health care system at such time as it becomes proclaimed.

I thought I might start off by telling you a little about the dental hygiene profession. Dental hygienists are licensed health professionals required to pass a licensing exam upon completion of their educational program. They provide a comprehensive range of preventive and therapeutic services. We are currently regulated by the RCDS, the Royal College of Dental Surgeons of Ontario, but we are looking forward to self-regulation under the Regulated Health Professions Act.

We are predominantly a female-dominated profession and work in collaboration with other dental health care

personnel, primarily dental assistants and dentists. As dental hygienists, I think we are particularly concerned about the delivery of dental health care to all segments of the population, but especially those which are currently not served or are underserved. By those we are also indicating groups that tend to be at high risk to dental disease. Seniors is one group, particularly those in chronic care facilities, in nursing homes and those who are home-bound.

Certainly, with the decline in dental caries, there has become an increased focus on periodontal disease. Some of you might know the term more familiarly by the word pyorrhoëa, which is what it used to be called. With that increased focus on periodontal disease, there is now an increased demand for dental hygiene services. Certainly, looking at the demographics, it indicates that there are going to be an increased number of seniors in the near future, one of those high-risk groups. The epidemiological studies tend to indicate that those seniors are going to be retaining those teeth and requiring more preventive and periodontal services, which are the services dental hygienists primarily provide.

This, then, I think represents a market for dental health care that we did not have previously. A lot of people lost their teeth by the time they reached their senior years or felt that it was just an inevitability that their teeth would be lost. We know now that is not the case. Certainly the need to ensure affordable, accessible dental hygiene care to the public is essential, and this forms the basis of our comments in this presentation and in our brief.

The first point relates to Bill 47, which is the Dental Hygiene Act. The additional page that was distributed relates to the controlled acts for dental hygiene. Unfortunately there was an error in the printing on page 2 of the document, but we will do our best to forward you a revised copy of that as soon as possible. That additional page outlines the two controlled acts for dental hygiene.

Our first comment relates to the provision of dental hygiene services, and more particularly those two controlled acts. As you can see, both of them are to be performed on the order of a member of the Royal College of Dental Surgeons of Ontario. Our concern is that restrictions will be placed on dental hygiene care by the interpretation of "on the order" of a member of the Royal College of Dental Surgeons of Ontario.

In the past, Ontario has had one of the most stringent interpretations of supervision in Canada and thus limited the delivery of preventive dental health care services. The ODHA stresses the need to define such an order so that it does not perpetuate dentistry's control over the dental hygiene profession or support dentistry's economic self-interests, and as such possibly limit access of those dental hygiene services to those who need it the most, the high-risk groups, the ones that we mentioned previously.

1430

At present, institutions and community service agencies outside of the scope of public health are required to employ a dentist and have him or her present in order for the dental hygienist to provide his or her services. Certainly the economics of this requirement renders the

implementation of many preventive programs financially unfeasible and results in gaps in the provision of services.

Using seniors as an example, because I have a number in my neighbourhood, many seniors, as we know, are on fixed incomes and many more have limited access to dental hygiene care. This is particularly because they have dropped out of the system, the dental health care system and they dropped out a long time ago and they really do not know how to get back into it. Therefore, often the majority of services that are required by seniors are of a preventive nature: regular cleanings, oral hygiene instruction, patient education, denture cleaning, those sorts of things. We feel that dental hygiene care needs to be both affordable and accessible for these individuals and that the scope of practice of dental hygienists must not be restricted in such a manner as to limit the availability of services provided by dental hygienists.

Our next point relates to the topical application of controlled agents. We support the RCDS in suggesting that there are substances that, when applied to the surface or on the tooth, alter the surface of that tooth and therefore should be controlled. In the practice of dental hygiene, the topical application of controlled agents, including such things as topical fluoride and pit and fissure sealants, differ from other topical applications by other health professions in that our application is in the mouth and the potential for systemic ingestion of a toxic substance is considerable.

Pit and fissure sealants are the one example that comes to mind. They have been around for many years, and certainly those of you with children might be more familiar with them, because you have taken your child to the dentist to have these sealants placed over the biting surface of the tooth. It is a preventive measure that looks to help prevent decay from occurring and therefore keeps the teeth filling-free. Certainly the technique in the application of pit and fissure sealants is critical to both the success and the safety of pit and fissure sealants.

Therefore, we recommend that the application of controlled agents be considered a controlled act and be restricted to qualified individuals—dental hygienists and dentists—who are fully cognizant of the toxic or irreversible nature of the agents and recognize the necessity for appropriate techniques to ensure the safety of the public.

Our third point relates to scope of practice. Admittedly, this point probably falls more under housekeeping, but we felt it was worth raising at this point. The Regulated Health Professions Act defines the scope of practice for dental hygiene, Bill 47, section 3, as follows:

"The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and, on the order of a member of the Royal College of Dental Surgeons of Ontario, the provision of restorative and orthodontic procedures and services."

This scope statement is inconsistent with other regulated health professions in that it includes the wording of a controlled act in the general statement. It is unnecessary for the phrase to appear in the scope of practice, as it is in the controlled acts section, and we recommend its deletion. As well, the authorization for provision of services, the "on the order" portion, is not included in any other

profession's scope of practice. So in terms of consistency throughout the document, we thought it worth raising this point at this time.

We therefore recommend that our scope of practice statement read, "The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means."

The last point that we have relates to the Regulated Health Professions Act, Bill 43, and more specifically the delegation of controlled acts. The concept of controlled acts identifies specific procedures that by virtue of their potential risk of harm to the public may only be performed by qualified individuals. While there are controlled acts to protect the public from unqualified individuals, there is also the power to delegate controlled acts to a totally unqualified individual. Although we can appreciate the need for delegation in specific situations, we question the rationale in permitting this generalized delegation of controlled acts.

In conclusion, certainly the development of new health legislation has been a long and arduous process for everyone involved. However, we are confident that the time and resources invested by all will result in a better health care system for both health care providers and consumers. I would like to again thank you for your time in listening to us and I would be happy to answer any questions that you have at this time.

Mr Beer: Thank you for your presentation. In terms of the statement in your scope of practice, what is the current situation in terms of how you practice? Is it similar to "on the order" of a member of the royal college? Does that describe the reality by which you work today under the existing legislation?

Ms Dempster: Currently, dental hygienists work under the direction and supervision of a dentist. The RCDS, which currently regulates dental hygiene, has interpreted that to mean that the dentist must be physically present in the suite of offices. That is primarily for private practice, although in public health there is somewhat of an exception in that dental hygienists do not work under the physical presence of a dentist. The reality, though, is almost a slightly different question, in that dental hygienists do work certainly in offices, in a dental office primarily, but the dentist does not always authorize the treatment that is going to be provided.

You are referring to our scope of practice statement or "on the order"?

Mr Beer: I was interested in how it is done today, and then I wanted to read that in terms of under the new act how it would operate, because one of the things I was interested in was your comment about the changing demographics of society, seniors and so on, and whether you could only practice in effect with a dentist, or would you see your role developing where you are going out into a senior's home, let's say, who is living by herself or by himself to do certain procedures and could that be done under the new act, where there would not necessarily be a dentist with you but you would have the authority to do certain procedures in the home.

Ms Dempster: Right now dental hygienists work under the direction or supervision, which means the dentist has to be physically present. At this point in time, community centres, nursing homes, anything outside of the public health system really cannot provide dental services unless the dentist is physically present, and that becomes economically unfeasible because a nursing care institution would then have to hire a dentist to come in and supervise the dental hygienist in the provision of the services that she provides. We feel that because of the demographics, because of the need that seniors have, particularly because there are going to be more of them and particularly because they are going to be retaining their teeth and have more preventive and periodontal needs, we need to ensure that dental hygiene services are going to be accessible to that group. Under the current system, the way dental hygienists are regulated now, that is not the case. What we have presented to us in this draft legislation is that we will function on the order of a dentist. We are not sure how that is going to be interpreted and we just want to be clear that we need to make sure that dental hygiene services are not restricted if that "on the order" is defined in a similar way to the way we practice now.

Mr Owens: In terms of your comments with respect to the application of topical fluoride and the application of pit and fissure sealants, you recommend that it be restricted to hygienists and dentists. Is that the current practice now?

Ms Dempster: Yes, it is. Topical fluoride and pit and fissure sealants, that service is provided by both dentists and dental hygienists at this time.

Mr Owens: So a dental assistant is not involved in any of that?

Ms Dempster: That is correct, because outside of taking X-rays or radiographs, upon a dental assistant having taken a specific course, and outside of preventive dental assistants, who are another level of assistant who can provide certain services—sorry, dental hygienists and dentists and preventive dental assistants can provide topical fluoride.

1440

Mr Owens: So your amendment is in fact maintaining the status quo, or legalizing the practice that you are already undertaking?

Ms Dempster: Yes, I guess you could say it is maintaining the status quo. We felt that there needed to be a reconsideration of the application of topical fluoride and pit and fissure sealants as a controlled act. It was issued as a controlled act at one point much earlier on in this whole process and then it was deleted as a controlled act.

Mr Owens: Do you have any idea why that was?

Ms Dempster: There were a number of reasons given. The primary reason that I remember Alan Schwartz giving was that in order to provide consistency in the legislation, there was topical application of a number of different agents by a number of different health professions, and if they made the topical application in our situation a controlled act, they would have to make topical application in every other health profession a controlled act. Our argument is that our topical application is different in that it is

intra-oral, potentially systemic, those sorts of arguments. But I believe it was a consistency argument that Mr Schwartz presented as his primary argument for deleting it from our scope of practice.

Mr Jackson: Are you familiar with procedures in other provinces as they relate to this specific issue of the delivery of your services to seniors in institutional and non-institutional settings?

Ms Dempster: Yes.

Mr Jackson: Can you share briefly with us what differences might occur nationally?

Ms Dempster: With respect particularly to seniors?

Mr Jackson: In particular to the concept of supervision as it relates to community-based—

Mr Dempster: Okay. I might pass that to Marg Walsh. She is our public health expert.

Ms Walsh: Currently, British Columbia allows an arm's-length practice of hygienists in delivery of care. In most of the other provinces there are not the numbers of hygienists. It is not that there is not the demand, but there is not the number of hygienists to be able to service that demand that is there and there is not movement in that area. Supervision requirements change drastically throughout the provinces. Most of them are under supervision.

Mr Jackson: What I am thinking of is that as we evolve in this province to a more community-based model for long-term care, hopefully one would suspect that dental services form part of that continuum of care. If that is the case, we are looking at expanding access in this province. Certainly the last two governments campaigned at one point in time during their history on that specific election promise.

Given that we may be moving in that direction, perhaps I can direct this question to staff, Madam Chair. If we are in a position to be discussing other ministries at the end of these hearings, perhaps we should have closer access to the draftspersons of the long-term care working paper to see its relationship to dental care for seniors in this province. That might be an appropriate line of questioning or access for this committee to that body. I understand the terms of reference are not even drafted yet for that public document, but hopefully they will be before this committee completes its activities.

The Chair: Comments are noted, Mr Jackson.

Thank you very much for your presentation. I would just mention for all groups that please feel free, at any time over the course of these hearings, if you wish to communicate with the committee, you can do so in writing, with a written brief or with a letter to any member of the committee, through the clerk. We would be pleased to hear any further comments that you have to make.

CANADIAN MEMORIAL CHIROPRACTIC COLLEGE

The Chair: I call next the Canadian Memorial Chiropractic College. Begin by introducing yourselves. You have 20 minutes for your presentation and the committee requests that you leave a little time for questions at the end of your presentation. Begin your presentation now, please.

Ms Moss: Madam Chair, members of the committee, I would like to introduce myself and my associates. I am Jean Moss, president of the Canadian Memorial Chiropractic College, and with me are David Dainty, academic dean, and John Mrozek, the director of our clinical sciences division.

I wish to thank the committee for allowing us to appear before you on this important occasion. At the outset, I should tell you that my term as president began on August 1, 1991. It is auspicious that one of my first orders of business is to appear before a committee dealing with what must surely be one of the most historic matters facing chiropractic and health care in decades.

The process of the Health Professions Legislation Review, and now the Regulated Health Professions Act, over the past eight years has provided Ontario with the unique opportunity to adopt an innovative approach towards regulation of the health care professions. This act is exceptional in that it has been supported by each political party during its term in office. All parties are to be complimented on their progressive approach to health care for the citizens of Ontario.

The Canadian Memorial Chiropractic College, or CMCC as we are fondly known, is a non-profit, charitable corporation registered in Ontario in 1945. For more than 45 years it has educated chiropractors for practice throughout Canada and around the world. This education has allowed patients to confidently seek chiropractors as their portal of entry into the health care system.

CMCC is unique among major health care educational institutions because it is funded only by its students and the membership of its alumni. We receive no direct funding from any level of government. It is the only chiropractic college in Canada and one of the most respected chiropractic institutions in the world.

CMCC joins with the Board of Directors of Chiropractic, whose mandate is protection of the public, and the Ontario Chiropractic Association, which speaks on behalf of the chiropractic practitioner, in acknowledging that there are two concepts which must be reconciled—the mandate of the practitioner and the protection of the public. Imposed upon CMCC is the added dimension of education for a broader jurisdiction than Ontario.

CMCC is concerned that the mandate of the institution be maintained. The fact that it is the only educational institution in Canada for chiropractors has placed upon it a special responsibility and burden. It is incumbent upon us to prepare students to practise in the various jurisdictions. We at CMCC would ask that you consider in your deliberations that Ontario has a special responsibility to the education and practice of chiropractic throughout Canada.

The issues of the qualifications leading to acceptance as a member of the profession and to educational and academic licensure are also of concern to us. We have, however, been assured that these issues will be dealt with by regulations enacted subsequent to the final legislation. We must rely upon such assurances and leave these matters for future consideration.

A further issue, one which may be peripheral to this committee but is of importance to us, is accreditation. CMCC is accredited by the Council on Chiropractic

Education (Canada) Inc, which establishes standards for the education of chiropractors. A change in the breadth of diagnostic scope would potentially affect our accredited status.

Chiropractic has been legislated within Ontario since 1925. This has allowed the public of Ontario the freedom of choice in health care for more than 65 years. This freedom has allowed the patient to obtain the benefits of chiropractic to the point where we are the second largest general, primary contact health care profession in Canada. CMCC would ask that you help to ensure that the Ontario public continues to have access to its choice of health care provider and that chiropractic students are exposed to the same broad range of clinical experience as currently exists.

As a provider of health care to the public through our three teaching clinics, we are concerned with the proposed legislation. Of particular concern are the scope of practice and the authorized acts in so far as they relate to the practice of chiropractic. In our opinion, it is essential that a chiropractor be allowed to continue to diagnose conditions related to other articulations, or, in the words of the act, "the joints of the extremities." These conditions have historically been diagnosed by the doctor of chiropractic. The practitioner is well educated to make such diagnoses, as approximately 600 hours of our program are devoted to the diagnosis and treatment of non-spinal articulations.

The education of the chiropractor is conducted in the classrooms, laboratories and clinics of the institution. We recognize that the educational process is separate from practice. However, 25% of the student's education at CMCC is spent in clinical experience dealing with the public, and therefore governed by the laws of practice in Ontario. A change in the legislation has the potential to affect a large portion of our educational program.

The satisfactory resolution of these issues to the benefit of both the public and the profession is CMCC's primary reason for making this presentation. Although we are in favour of the spirit of the legislation and where it is taking health care in Ontario, we have concerns, as expressed above, about the impact the new act, in its present form, would have on the education of chiropractors in Canada.

We wish to thank you again for allowing us to appear before you. We would be pleased to attempt to answer any of your questions.

1450

Mr Owens: Let me begin by congratulating you on your election to the position of president. I think all committee members from all three parties share your concerns around standards of education, standards of practice, and making sure we have accreditation processes that reflect the public's concern around safety and quality and efficacy of treatment. I think we can resolve your concerns satisfactorily.

You seem to be fairly happy with the legislation as a whole, if I am hearing you correctly, and the intent of the legislation. I am wondering if you could tell the committee how this legislation will benefit yourselves, but also benefit the public in terms of accountability, access and issues like that.

Ms Moss: With regard to the legislation, we are basically happy with it, with the exception of the inclusion of other articulations, or "joints of the extremities," as a diagnostic area for chiropractors. We see this as an area of concern for us.

Mr Jackson: Because it is not included.

Ms Moss: It is not included, yes.

Mr Beer: I just wanted to be clear on "the joints of the extremities." At the present time you diagnose those conditions, or chiropractors may do that?

Ms Moss: Yes.

Mr Beer: In the education program at your college, you can teach that and presumably could still teach it in the educational setting, but the concern would be that 25% of that instruction is practical, and if it is not clear that you are allowed to practise that, this obviously has an impact on the profession. Have there been any discussions with the medical profession? Are they opposed to your being allowed to diagnose the joints of the extremities? Where is the essential conflict that would seem to prevent you from doing something that you have been doing, if I understand your brief?

Ms Moss: We have not been involved in any discussions with the medical profession, and so I am unaware of any opposition from the medical profession. I cannot really respond to your question more fully than that.

Mr Beer: Was there a reason, in terms of the discussions and the development, why this was not made specific?

Ms Moss: Not to my knowledge. Most of those discussions were held with the Board of Directors of Chiropractic, and I am sure they would be able to answer that question. They will be making a presentation later in the month to the committee.

Mr J. Wilson: That was essentially my question: Why are we being asked to narrow your scope of practice? Perhaps we will take a run at it again.

Just out of curiosity, what are the educational requirements? Do you have to have a post-secondary degree prior to entering your college?

Ms Moss: Entrance to the college requires that a student have two years of university education, with prerequisites in certain subjects. Approximately 85% of our students have a prior degree, either an undergraduate degree or, in some cases, graduate degrees.

Mr J. Wilson: And it is a three-year course?

Ms Moss: It is a four-year program.

Mr Jackson: I am having difficulty with the notion of the reduced diagnostic capacity per the extremities. I personally use, and am a big supporter of, chiropractic services. Before we prorogued, I sustained a baseball injury. I went through my physician, spent a pile of money having it attended to, then went to my sports physio and spent several hundreds of dollars in the process there, and still had no use of my arm. In the process of telling my chiropractor that my shoulder muscle is now somewhat atrophied, because I have no use of my arm, he immediately realized that my wrist was my problem. Within five minutes

he had relieved me of the problem, which the X-rays did not show and which the physio had confirmed was probably my problem. He had been unable to do the manipulation, but only work with the muscles.

I relate that story simply because the more I use your services, the more I realize how much less an expense to OHIP these things become when the kind of counselling I was being given from—that is not to undermine in any way the good intentions of my physician. He is a sports expert himself. But I really have a hard time believing the work you are doing should somehow be limited when in fact it works so well. Certainly Dr Bob Wingfield, who has had senior positions with the Ontario board, who takes care of me—I was quite impressed by the fact, by those points I want to share with you.

So we will be looking at this list, but I wanted to put on the record my bias in support of your concerns because I certainly am impressed by what I think we can save OHIP by the process of allowing these procedures.

The Chair: I have a request for Mr Wessenger to clarify the ministry's perspective.

Mr Wessenger: The perspective I would like to give from the ministry's point of view is that under the regulation under the Drugless Practitioners Act at the present time, there is no right of diagnosis given to chiropractors. It is really just a question of what treatment they give, and so we see it as an expansion of rights. If you look at the new act, you will note that the chiropractor is given the right of "the assessment of conditions related to the spine, nervous system and joints of the extremities." So they have the jurisdiction over the assessment of the joints of the extremities, and they do have, of course, the diagnosis, which they did not have before, with respect to "disorders arising from structures or functions of the spine." So we see it as giving them an increased jurisdiction in this whole matter. That does not mean we cannot consider the representations made, but I think it should be made clear that they are getting an increase in jurisdiction under this act.

Mr Jackson: On that point, though, using my own example, we have limited chiropractors' ability to utilize access to X-ray facilities in hospitals—the Chair would be very familiar with this ruling in this province—yet had my chiropractor seen the X-rays of my wrist, he would have been able to diagnose it, when the X-ray technician and the physician both missed it.

I know we are talking about semantics here, and the difference between "diagnosis" and "assessment" may not be lost to legal counsel, but I can assure you that in practice out there, there is some concern being expressed here by the deputants. Perhaps we should ask if they concur with that statement of the parliamentary assistant, but in my own example my chiropractor does not have access to those X-ray services at the hospital should he need them to perform a diagnosis or the proper assessment of my wrist.

Mr Cordiano: I want to ask for a clarification from legal counsel.

Mr Wessenger: I think I will ask ministry staff, but I think we are on an issue that is somewhat not related to

this act, which is the whole question of access of health records to other professions.

Mr Cordiano: I would rather concentrate on this question again which crops up from time to time. The distinction between diagnosis and assessment, I think, is what we are dealing with.

Ms Bohnen: Okay. We are dealing with two issues here. First of all, as you say, there is the problem of the distinction between assessment and diagnosis, but the other issue for chiropractors is a little different. The review recommended that chiropractors be authorized to diagnose dysfunction and disorders of the spine and the effects of those spinal disorders and dysfunctions on the nervous system, and that would include disorders and dysfunctions of the articulations that arise from the spine. What the review recommended that chiropractors not be authorized to diagnose are disorders and dysfunctions of the articulations that have no connection whatsoever to the spine. What I believe the chiropractic profession is seeking is statutory authority to diagnose in relation to these unrelated articulations.

As I said, that narrow issue was superimposed against this assessment/diagnosis issue. I think I have stated the issue correctly.

The Chair: Thank you for your presentation.

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GOVERNING BOARD OF DENTURE THERAPISTS

The Chair: I would like to call the Governing Board of Denture Therapists. We ask that you introduce yourselves to the members of the committee and if you wish to leave some time at the end of your presentation for questions from committee members, you have a total of 20 minutes for your presentation.

Mr Southby: Good afternoon. My name is William Southby and I am the chairman of the Governing Board of Denture Therapists. With me are René Tremblay, a member of the Governing Board of Denture Therapists, and Robert Gaspar, a dental therapy teacher at George Brown College. We are all practising denture therapists.

The Governing Board of Dental Therapists appreciates the opportunity to make a submission to the standing committee on social development with respect to Bill 50, the Denturism Act, and Bill 43, the Regulated Health Professions Act. The governing board has actively participated throughout the consultation process which has brought us thus far, and we commend all those who have worked long and hard to develop this new legislation. Reform of the several pieces of legislation currently governing the health disciplines is long overdue, and we support the spirit and intent under this Bill 43.

Currently, there are 450 licensed denture therapists regulated under the provisions of the Denture Therapists Act. The governing board has regulated denturists since 1974. Presently, denturists engage in two types of practices: (1) an independent practice providing complete upper or lower dentures directly to the public; and (2) a supervised practice in a dentist's office providing partial dentures to the dentist's patients who retain some of their natural teeth.

Under the current legislation, denturists are not permitted to provide partial dentures directly to patients in their private practice. Many denturists practise both independently in their own offices and in dentists' offices.

Primarily, we wish to support the proposed scope of practice for denturists contained in sections 3 and 4 of Bill 50. These provisions permit denturists to provide partial dentures directly to the public in their offices. It will no longer be necessary for denturists to travel to a dentist's office to provide this service. From the regulatory perspective of the governing board, the simplification of the provision of denture services to the public appears appropriate.

Historically, in 1980 the Ontario Council of Health commissioned Professor Bernard Dickens, PhD, LL.D. of the faculty of law, University of Toronto, to conduct a review of denture services provided by dentists and denture therapists in the province. Professor Dickens's report was submitted to the council in April 1981 and later that year the council's statement on denture therapy was submitted to the then Minister of Health, Dennis Timbrell.

Professor Dickens recommended that the Denture Therapists Act, 1974, be amended to permit registered denture therapists to design, supply, adjust and repair partial dentures without supervision of a dental surgeon. His report goes on to say, "The intention of this recommendation is to permit exercise of professional judgement on referring patients to dentists before work on partial dentures is undertaken. Professional judgement is reinforced both by legal accountability and by professional disciplinary action for incompetence and professional misconduct." Professor Dickens's recommendation was not implemented.

More recently, the same recommendation was made by Mr Alan Schwartz, co-ordinator of the Health Professions Legislation Review, whose work has resulted in Bill 50, and the omnibus Bill 43.

Entrants to the profession are graduates of the denture therapy program at George Brown College of Applied Arts and Technology. Currently, the program is three years in length, and we attach appendix A which details the components of the curriculum for the program. From this, you will note the number of hours of instruction devoted to subjects such as anatomy, biology, histology and pathology, as well as the more technical aspects of denture services.

For graduates, the governing board conducts an ongoing continuing education program which has included training by licensed dentists on topics such as oral pathology, oral radiology and removable partial dentures.

When Bill 50 becomes law, it is our intention to provide an upgrading program conducted by the George Brown College for practitioners already in the profession to enhance their qualifications to provide partial denture services independently.

Presently, up to 60% of denturists have significant experience providing partial dentures in a supervised setting, and many of our members are also trained dental technicians and therefore have significant experience in the technical end of providing partial dentures.

Attempts have been made by some dentists to discredit denturists by suggesting patients have suffered harm caused by partial dentures made by denturists without supervision of a dentist. However, when the governing board attempts to investigate these allegations, supporting information is not forthcoming. Indeed, when the governing board receives information about illegal partial dentures, it comes from sources such as insurance companies or social service agencies, not from complaints from the public.

The annual reports published by the governing board attest to our record of enforcement of the current legislation. During the past seven years, the governing board's discipline committee has dealt with 16 cases of denturists exceeding lawful scope of practice of making unsupervised partial dentures. This record also indicates the public and the denturist profession have difficulty in accepting the current restrictions. It appears from the cases we have investigated and prosecuted that the public's demand for the services of partial dentures from denturists is based on cost and quality of service.

1510

As regulator of the denturist profession, the governing board supports the current bills. We have three suggestions for improving the legislation:

1. Paragraph 26(2)11 of Bill 43 controls the following act:

"Fitting or dispensing a dental prosthesis, orthodontic appliance or a device used inside the mouth to protect teeth from abnormal functioning."

This provision does not protect the public, however, from the repair or relining of dentures by completely unqualified persons. If a denture is repaired or relined improperly, it can result in occlusion problems, ill-fitting dentures, oral tissue damage, loss of mastication and even temporomandibular joint dysfunction, which is the hinge of the jaw.

We would suggest that paragraph 26(2)11 of Bill 43 be reworded as follows, "Fitting, repairing, relining or dispensing a dental prosthesis..." etc. A corresponding amendment would have to be necessary for section 4 of Bill 50.

2. Communicating conclusions. Paragraph 26(2)1 of Bill 43 controls the following act:

"Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion."

As presently worded, the provision is overly broad. It would include, for example, a statement by a denturist to his or her patient that maybe the porcelain piece on their dentures was causing damage to the opposing dentition or the patient's natural teeth. A simple solution would be to exempt communications made by a member within the scope of practice of the member's profession.

3. Holding out. Subsection 15(3) of Bill 50 states:

"No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a denturist or in a specialty of denturism."

This provision only prohibits people from pretending they are registered. It does not otherwise prevent unqualified persons from misrepresenting their qualifications. If the phrase "to practise in Ontario" were deleted, a more appropriate level of protection from misrepresentation would be provided. The provision would then read:

"No person other than a member shall hold himself or herself out as a person who is qualified as a denturist or in a specialty of denturism."

The governing board would like to thank the standing committee for the opportunity to make these submissions.

Mr Beer: Thank you for your presentation. At the present time, how do people come to a denturist? Would most come through a dentist? I am trying to understand how you function in relation to dentists.

Mr Southby: Presently, we are completely independent regarding, we will say, upper and lower dentures. Most of our patients, those who have been in business for a while, come on recommendation, signs and advertising. We are just like a dentist's office really, except it is a denture therapy clinic.

Mr Beer: At the present time, if somebody comes who requires a partial denture, what do you do?

Mr Southby: We inform them of the act. If we decide to make the partial denture, we make arrangements with a dentist to do the supervision.

Mr Beer: What would that mean in real terms?

Mr Southby: In real terms, as I said, they usually have to go to the dentist's office with the patient and perform the necessary function.

Mr Beer: So the denturist would go with the patient?

Mr Southby: Yes, or meet them at the dentist's office. But the patient is the dentist's patient. The patient has to pay the dentist for this service, not the denturist.

Mr Beer: In terms of what Schwartz recommended and the earlier study that you noted by Professor Dickens, they both recommended you be permitted to do the partial denture independently.

Mr Southby: Without supervision.

Mr Beer: We have heard a couple of presentations that question that, because of the education of denturists, not being able to see perhaps some of the problems that might arise with a partial denture. I know in your brief you mention some of the programs and courses denturists must take. In your judgement, is that similar to what a dentist would be taking who was also going to be dealing with partial dentures? What would be the difference?

Mr Southby: The big difference is that the dentist is a professional trained in what we term as preventive dentistry, who would X-ray, do the usual things and fill, clean, extract and do whatever is necessary in the mouth to make the mouth completely healthy. From there on in, with this knowledge, in co-operation with a dentist, not supervision, the denturist could make the partial denture with the knowledge he gets from the dentist. The patient would be so much better off economically, if nothing else, because he basically does the same thing under the so-called supervision of a dentist, but the dentist gets the fee for the partial denture.

You see, the dentist is paid for anything the dentist does when he fills your teeth, cleans them and X-rays them. That is not included in the cost of the partial. In regard to their pricing, this is how it is done. What we are saying is that we can provide this partial denture without the supervision of the dentist. Many of us have been doing it for years and years. We need the co-operation of the dentist, but not the supervision.

Mr Owens: I would like to touch on a sensitive area, that is, the area of complaints. You mentioned that you have had 16 cases of denturists exceeding the scope of practice by making unsupervised partial dentures. How many complaints did you receive from patients or organizations about actual harm that had been done to patients?

Mr Southby: To my knowledge we have not had any. There was one article in the Ontario Dental Association journal that purported that harm was done and even published a photograph of it, and when it was investigated it was found that it was not a denturist at all. It was an illegal dental technician or somebody who had made the denture.

Mr Owens: To follow up on that, do your patients know how to complain? Is there some procedure outlined in your office code of ethics?

Mr Southby: We have a complaints procedure, but patients complain usually because their dentures do not function. They either hurt or they cannot chew with them or something is wrong, so they go back to the practitioner. If they do not get satisfaction from the practitioner, then they come to the governing body with a complaint, which is then investigated.

Mr Owens: Where would these cases we have heard from different representatives of the dental profession come from: improper plates, teeth that are misaligned and all sorts of horror stories? Are these manufactured stories?

Mr Southby: They have to be, because when we investigated these things there was no follow-up with this evidence. I do not know what they have told you, but we do not know that this was done. If it was made illegally, for some reason they will quite often say, "Oh, a denturist made this," whereas it was a dental technician who did it on the side or something like that. A lot of people do not know the difference between a denturist and a dental technician.

Mr Jackson: Perhaps it would be helpful to the committee if you were to get us a copy of the case you cited. I am a little uneasy with your suggesting that you think it might have been a dental technician. If that is the basis of your recollection, I would rather you got us the exact case.

Mr Southby: Yes, we have it on record. Our investigator went right to the office.

Mr Jackson: I would like a copy of that. You said you thought it was something like a dental technician.

Mr Southby: Yes.

Mr Jackson: I would like to read the case as opposed to leaving that impression in my mind.

Mr Southby: Fine.

Mr Jackson: My second question is for legal counsel. On page 6 there is a statement made about the holding-out

provision with the deletion of "to practise in Ontario." Is that legal counsel's interpretation of the effect of—

Mr Southby: Yes, it is.

Mr Jackson: I am directing my question to legal counsel.

Ms Bohnen: I am not sure I understand.

Mr Jackson: I am asking if you agree with the assertion that the effect of deleting the words "to practise in Ontario" is that it affords a greater level of protection. I am really asking, do you concur with that statement?

Ms Bohnen: It would afford different protection. It would preclude someone who is qualified, let us say, to practise as a dentist in Quebec from saying that, even though it may be correct. The harm we were trying to get at and the way it is drafted is misrepresentations that someone is qualified to practise in Ontario.

Mr Jackson: If time permits, are there other examples where that broadly based statement exists in health professions to ensure that you cannot set yourself out as having been accredited unless you are capable of practising in that province?

Ms Bohnen: To my knowledge, the existing health professions legislation in Ontario does not speak to the issue of jurisdiction at all.

Mr Jackson: Okay. I will pursue that with you later, then.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today. We have all received a copy of your brief and as the committee hearings go on, if you have anything further you wish, please feel free to communicate in writing with the committee.

Mr Southby: Thank you. Mr Jackson, should I send it directly to you?

Mr Jackson: To the clerk, and other members of the committee will be able to have a copy.

1520

STEPHEN ABRAMS

The Chair: I call Stephen Abrams and ask that you come forward now. You have 10 minutes to make your presentation and we ask you to leave some time for committee members to ask some questions.

Dr Abrams: I would like to thank the committee for giving me the opportunity to address you today on the factors and techniques involved in fabricating a removable partial denture. As background, I am a practising dentist and upon graduation I was involved in establishing a group practice in Scarborough, Ontario, which has been providing a full range of comprehensive oral health care services to the community for the past 11 years.

The focus of my presentation is the replacement of a patient's missing teeth utilizing a removable partial denture. It is fundamental to diagnose the patient's oral health status prior to deciding what options are best to restore missing teeth. A partial denture is not necessarily the best option in each instance.

I have selected a fairly typical case, or a typical patient, in our practice in order to illustrate for the committee the various techniques used in the delivery of this service. The patient has given consent to having the photographs you have in front of you used today. I have also supplied the committee with a model so you can actually see what a partial denture is. This particular patient arrived in our practice in May, 1991 with the smile that you see in figure 1 in front of you. A view of the upper jaw in figure 2 revealed a few missing teeth and some old fillings that needed some attention.

Due to the nature of the work required, we took a panoramic X-ray, which revealed a number of hidden problems, which is in figure 3. There were two very infected roots in the back of the mouth, and I have labelled those A; a large back tooth with extensive decay and an abscess around the root, which I have labelled B; and finally, a front tooth with an abscess or an infection, which I have labelled C. None of these was readily visible to the naked eye, as you can see from going back to the previous picture. A thorough examination of both gums and supporting jawbone revealed that the upper right back tooth and front tooth had inadequate supporting bone and, as such, any type of false tooth should not add additional stress to these teeth. The construction of any prosthesis must take this into consideration.

Our patient was now given three different options for replacing these missing teeth. We suggested a series of dental implants, fixed bridgework consisting of a series of caps and false teeth or a removable partial denture. In this situation, both the patient and I believed that a removable partial denture was the best treatment option. It would provide our patient with a complete set of upper teeth in a very short time frame and, if designed properly, it would fit firmly without exerting undue pressure on the existing teeth. The partial denture could also be modified very easily if down the road one of the teeth were lost.

With this decision made, treatment commenced. The infected, buried roots were removed to allow the gums and bone in the area to heal properly and provide additional support to the teeth that we were going to use for anchorage. The upper right front tooth and the upper right back tooth both had root canal treatment performed on them in order to save these teeth and treat the infected nerves in them. Old, worn-out fillings were replaced and new ones designed with a view to being involved in anchoring the prosthesis. The areas of tooth decay were also restored utilizing materials that would wear well once the partial was placed.

Along with the restoration of the teeth, I also had our hygienist clean and polish all tooth and root surfaces, removing harmful tartar and stain. Our hygienist, who was apprised of the design of the denture, spent time teaching our patient how to care for his teeth and the new denture. With this phase completed, I reviewed our final X-ray, which I have provided for the committee in figure 4, to make sure that all the problems had been treated, and examined the health of teeth and gums.

The denture design involved resting the denture on both teeth and gums. In this way, chewing forces would be

evenly spread and no one area would be exposed to harmful, excessive force. The denture was to be cast in a very light metal which was thin and strong. I provided the committee with a sample of it. It has never been in a patient's mouth and I encourage you to sort of move it on and off the model to see how it works.

Figure 5 shows a picture of the denture resting on a model of the patient's mouth. The metal pieces I have marked A are areas where the denture actually rests in depressions we have cut in the tooth. Not only do these rests or depressions allow the denture to seat firmly, but they also transfer the chewing forces to those teeth which can best withstand these forces. If the denture were to rest solely on soft gum tissue, these chewing pressures would force the denture against soft gum tissue, stripping it away, and with it the bone which anchors the teeth in place.

The areas on figure 5 that I have marked as B are clasps or hooks that engage only the strongest teeth to help anchor the denture in place so that it will not come out when eating. As you can see, we did not anchor the denture on a tooth marked C, as this is the one we alluded to earlier which is not a very strong anchor tooth but does provide an adequate rest.

One final observation on that particular figure is an area I have marked D. This particular clasp design is designed to provide a very good grip on the teeth involved without coming out on to the front surface, where it would be visible in a smile. In order to do this, I removed some enamel from the side of the tooth where it rests. This does not endanger the tooth but will provide a very firm anchorage for the rest of the teeth.

Figure 6 shows a mirror image of the denture in our patient's mouth, and figure 7 is our patient wearing his new denture. At this stage, the false teeth, which I have marked A, blend very well with the existing front teeth except for one of the patient's own teeth, marked B. This tooth, which we described earlier, had required treatment for an infected nerve or root canal. One of the problems with a long-standing infection is that these types of infections will discolour teeth. By applying the correct tooth-coloured filling material to this tooth, we were able to match and blend the colour with the other teeth, and the result is what we see in the bottom photograph you have in front of you marked figure 8. Our involvement does not stop here; it continues. Our patient returns to our practice to ensure that the denture is fitting well and that there are no sore spots, and also to review home care.

We also emphasize the importance of a semi-annual dental checkup. I have already arranged this appointment for the patient. These checkups provide us with the opportunity to monitor the health not only of the teeth and gums, but also to monitor the fit and wear of the prosthesis. Not only will we clean our patient's teeth at this time, but we will also clean the denture and tighten the clasps, which are not designed to be too rigid. The bit is also examined at each annual checkup and as the denture ages, the wear of the denture teeth are monitored so that all teeth, both natural and denture teeth, contact evenly when chewing.

This case illustrates the importance of a comprehensive approach to the delivery of dental care. I emphasize that

partial dentures are but one small part of the overall treatment and cannot be made without consideration for the following areas: the health of the anchoring teeth, gums and bone; the strength of the fillings used in the anchoring teeth; the patient's chewing pattern; the colour and shape of both the natural and denture teeth; the anticipated lifespan of natural teeth; and other methods of tooth replacement.

These factors are all part of the diagnosis a dentist does before commencing work. These factors are not part of the range or training of a denture therapist. Because of the lack of training and education in dental radiology, gum problems and root canal problems, methods of filling and restoring teeth and pathology of the mouth, the denture therapist cannot even begin to consider any of these factors before manufacturing a prosthesis. Had any one of these factors been omitted from the case I have shown you today, the results would have been disastrous.

Costs of these services are also a consideration. The range of procedures I have provided here today are available to all. This particular individual we have used as an example was on a welfare assistance program at the time. With support from the municipality, we were able to restore the dentition to the state you see them in today. Furthermore, maintenance should be very inexpensive.

Partial denture construction also involves cutting natural teeth in order to allow the denture to rest properly. Improperly designed rests will cause tooth decay and excessive and harmful forces on anchoring teeth, which may lead to their eventual loss. This will also increase the cost of the service.

Finally, partial dentures are part of a long-term oral health care plan developed by dentists and patients. The patient understands how to care for the prosthesis and what potential problems may be encountered. The dentist watches and cares for the remaining dentition, the prosthesis and the overall oral health of the patient.

Having considered the facts, I strongly believe that dentists are the only professionals qualified to diagnose properly the need for partial dentures. Furthermore, a denture therapist should become involved in this service only under the supervision of the dentist.

Thank you for your time and consideration. I will entertain questions.

1530

Mr Owens: Have you kept any type of statistics or have you done any tracking with respect to patients coming to your office who have seen denture therapists who are now having difficulties? I am not talking about discomfort difficulties, but serious problems with their teeth, the denture itself or teeth going off in different directions?

Mr Abrams: When patients come into the office we usually do not ask, unless we need to get records, where they have been. If a patient comes in with a problem with a partial denture, they just want me to take care of the problem and get them out of pain and discomfort, so I do not bother tracking who did what, where. The service the patient wants me to provide is dental care, and who did what to them prior to that is not of importance. What is of

importance is what is wrong, how we go about fixing what has gone wrong and how we provide something that is maintainable over the long term. So I have no idea where a lot of the things are done. In my feeling it is really none of my business.

Mr Jackson: Thank you for your graphic demonstration. It is helpful. Just for my own personal interest, how much did that whole procedure cost and how much did the municipality kick in?

Dr Abrams: The municipality of Metropolitan Toronto covered all of the procedures that you saw here today. They establish a fee guide or schedule that dentists in Ontario work by. As I can recall, I think the partial denture on that is covered at a rate of \$325. For the rest of it I do not have the figures at hand that could provide that breakdown for the committee. But there was a lot of work done.

The Chair: Thank you very much for your presentation.

PETER APSE

The Chair: Mr Peter Apse. You have 10 minutes for your presentation and we would ask that you leave some time for questions if you wish.

Dr Apse: Thank you for the opportunity to come and speak to you today and address you on the issue of the treatment of the partially dentured patient. As background, I am a dental educator at the University of Toronto, faculty of dentistry. Specifically, I am a specialist in prosthodontics, which is treatment of missing teeth in patients, in people, and I teach undergraduates and graduates in specifically that kind of treatment.

In the 10 minutes or less I would like to bring to your attention two aspects. One question which was raised before: What is the education background that we provide our students upon which they can graduate and practise dentistry? Second, what are the long-term effects of our treatment of our prosthetic intervention in a patient and how is the dentist suited to deal with these?

Let me start with familiarizing you with the prosthetic course or curriculum at our faculty. Generally speaking, prosthodontics or prosthetics, which is a treatment using artificial materials to replace missing teeth, is about a 20% segment of a four-year course. It is also one of the more complex subjects that we deal with in the sense that it encompasses every aspect of dentistry: radiology, radiographs, as you were shown by Dr Abrams, fillings, gum disease, surgery, pathology, hygiene, orthodontics and jaw joint problems, all of which are integral parts in the decision-making on the type of treatment that we can render the patient, how we are going to render it, the design of it and what are the long-term effects.

I am going to outline the approximate four years in very quick order. In the first year of a DDS, doctor of dental surgery degree, the student is trained in dental materials, which provides a background in the properties of materials, specifically in properties of materials used in prosthetics, their biological compatibility and their effect on the host, in this case, the patient. Also within the first year, referring only to subjects that are directly related to prosthodontics, the students are introduced to the intricacies of

occlusion, which consists of how the jaws come together, the masticatory system, how we chew, how we open our mouths, how we speak; all these factors are taken into consideration.

It is an exquisitely sensitive structure, as you may know, since you can very readily discern minute particles in your mouth that you can quickly and deftly bring to the forefront with your tongue. We also know that if the dentist has inadvertently left a restoration somewhat high, even microns high, we are subject to some discomfort which, if we relaid it or moved it laterally, we can say if we put a partial denture in, which you have seen examples of, that this factor will certainly introduce some aspects into our bite, into our occlusion, into the muscles of the jaw, into our joints.

Going to the second year, the first official prosthetic course is presented, approximately 140 hours of clinic or laboratory time and lecture time. That does not include reading time that the student has to do, which is another approximately 50 to 75 hours. That is in the second year of the course.

We start off with in effect giving the student an understanding of what happens when we lose teeth, what happens when we lose one tooth. Simply, the loss of a single tooth will affect the arch, both the arch in which the tooth is lost and the opposing one. The effect of loss of one tooth will upset the balance, the continued movement of the teeth that occurs one against the other, the back tooth bracing against the one in front. All of a sudden we lose one segment, we lose the continuity of that arch, the tooth starts drifting forward, tilting forward and the opposing tooth starts erupting out.

Another subtle, perhaps not so subtle at times, change that occurs with lost teeth is that we lose face height. We have all seen patients, people, who do not wear dentures. They walk in and their chin is approximating their nose. That in effect is extreme, but if we take it down back to where we lose some of the back teeth and we lose the support of our bite, which can be quite severe, then we will gradually lose this face height and the chin will come closer and closer to the nose. If we do not deal with that problem, it can have repercussions in what we call the temporomandibular joint, jaw joint, muscles of mastication.

After we have brought the students to an understanding of the effect of tooth loss, we then follow through with the principles of the partial denture. This involves the marriage of the mechanism of the partial denture, how it is held in the mouth—I mean, it has to hold in there somehow or it will just fall out when we eat—and the biological aspects of the retaining teeth. The teeth are going to hold this partial denture in place. Unless we consider the biology of teeth, we can very readily overload them and we can very readily cause their premature loss. It is therefore the dentist's responsibility to balance that risk that we put on the retaining teeth with the benefits to the patient of using a partial denture.

During that second year, and we are still in second year, students take treatment plan design and consider the construction of partial dentures for approximately 10 cases.

In the third and fourth year prosthodontics course, the students are exposed to what we call fixed prosthodontics, in other words bridges and crowns, a treatment plan, and fabricate partial dentures for clinical patients on the clinic floor. Students at this level are expected to integrate their knowledge of medicine, in other words, they have to take the health of the patient into consideration, the bite or occlusion, periodontium, which refers to gums, radiography—all these aspects in the design and fabrication of a partial denture. This interrelationship between different disciplines that we are exposed to at the faculty ensures that the patient's dental health is the prime consideration in our treatment.

Furthermore, the student is made aware of the importance of long-term follow-up and maintenance of the mouth at optimum health. Oral hygiene, diet, frequent recalls, are an integral part of the overall treatment that the student is taught. Prosthetic treatment is like the hub of a wheel with the student borrowing from the other aspects of dentistry in designing and preparing the prosthetic treatment. It is not just a technical procedure, but rather the integration of biological aspects with mechanical ones. One without the other will end up in catastrophe.

The second part I want to allude to is the relationship of a partial denture with the continued health of the patient. We have put something in a patient's mouth; how is that going to affect the patient? Missing teeth generally result in aesthetic problems; in other words, the appearance of the patient may not be to his liking, missing front teeth particularly, functional problems where the posterior teeth, the back teeth, are missing, he cannot chew very well, or both. A well-designed partial denture that has taken into consideration remaining tooth health, and the ability to sustain the increased loading as we might expect from a partial denture, is often a solution, a good solution, to the problem. It is very frequently used in practice. Although technical and biological factors are considered, the mere presence of a foreign object, such as a partial denture, will induce ecological changes in the mouth. We are going to get changes, whether we like it or not.

The Chair: I have to ask you to sum up now, please.

Dr Apse: With the presence of a partial denture, the bacteria and plaque increase placing the patient at greater risk. These risk factors can be minimized through long-term care of the patient. The provision of prosthetic treatment for the partially edentulous patient is not just a mechanical one. It is and should be rooted in a strong biologically based background such as is provided in dental education. We are not selling partial dentures, we are selling a health service.

1540

ONTARIO DENTAL NURSES AND ASSISTANTS ASSOCIATION

The Chair: I call next the Ontario Dental Nurses and Assistants Association. Begin your presentation by introducing yourselves to members of the committee. You have 20 minutes for your presentation and we would ask that you leave a few minutes at the end of your presentation for

questions from committee members. All members have received your written remarks.

Mr Miller: My name is Jeffrey Miller. I am an executive director of the Ontario Dental Nurses and Assistants Association. With me is Charlotte Peer, our president. The Ontario Dental Nurses and Assistants Association was formed in 1931 as a registered, non-profit voluntary organization for dental assistants. We estimate there are just under 10,000 dental assistants in Ontario. ODNA's current membership is 6,537. Approximately 93% of our membership maintain voluntary certification as a verification of occupational competency.

The Ontario Dental Nurses and Assistants Association recognizes: (1) the need for more educational opportunities for dental assistants to upgrade their skills in the areas of restorative and preventive dental health care assisting; (2) in light of the current health crisis, all dental assistants require access to appropriate dental health care education in prevention of disease transmission; and (3) that the regulation of dentistry should have the statute that refers to the preventive dental assistant revised and updated to include a mandatory recognition of allocation of duties to an Ontario certified dental assistant level 2 or the preventive dental assistant. The council of the RCDS has agreed with our proposal for an Ontario certified dental assistant level 2 program.

Dental assistants in the province of Ontario are employed in private practice, hospitals, public health units and educational institutions such as colleges of applied arts and technology. For the most part, except in the rare instance of an educational institution, dental assistants are employed by dentists and supervised by dentists.

Appended information on the next page basically outlines where we are as of now. Dental assistant education, that is, where dental assistants are educated: (1) certificate programs offered at community colleges; (2) three Ontario secondary schools offer diploma programs in dental assisting education, concurrent with secondary school graduate diploma requirements; (3) certificate diploma programs offered in Ontario at private vocational schools—there are four of those and they have different campuses throughout the province; (4) on-the-job training is still an acknowledged avenue for dental assisting educating in Ontario, and that is pretty well the way it is right across North America; and (5) out-of-province dental assisting education is recognized and currently in great demand, and it is the only opportunity available to achieve preventive dental assistant status in Ontario.

Our political issues, we have discussed, would be: (1) the ODNA lobby for the expansion of responsibilities for qualified dental assistants; (2) the Royal College of Dental Surgeons of Ontario and the Ontario Dental Association are on record in support of the expansion of responsibilities of an Ontario certified dental assistant level 2 program or the reinstatement of the preventive dental assistant program; and (3) under the current system only dental assistants who attain their dental assisting education credentials in other provinces may be listed as a PDA in Ontario.

Regulatory: Dental assisting as an occupation is not regulated in the province of Ontario. However, there are

two regulations that provide legislative jurisdiction for dental assistants to perform expanded functions under the order of a dentist:

1. The Healing Arts Radiation Protection Act provides for dental assistants with recognized training to take and expose dental radiographs—training concurrently available. Note, this intra-oral duty is not in the public domain; it is covered by a listing of credentials.

2. Regulation 447, section 49, provides authorization for dental assistants who have successfully completed a course of study which has been approved by the Council of the Royal College of Dental Surgeons to be listed as PDAs. Currently, Ontario certified dental assistants must go out of province to access this educational opportunity and subsequent occupational listing by the college.

At the present time, 12 Ontario CDAs are in Prince Edward Island upgrading their skills for listing in the province of Ontario, and a second class is scheduled for September 15, 1991. Ontario dental assisting education has fallen sadly behind the national standard. Ontario residents with no alternative, being forced to seek continuing education in their chosen career in other provinces, is currently a flaw in a tired system.

I will just return to my original document with our recommendations, which are covered on page 2.

1. That the Ontario certified dental assistants level 1—which is a voluntary credential of dental assistants who possess recognized training—have an opportunity to expand their dental assisting education to the national level 2 status, which includes the following duties: dental radiograph, HARP, which is currently listed; application and removal of rubber dam; taking preliminary impressions of teeth for study models; application of matrices and wedges; oral hygiene instruction; dietary counselling relative to dentistry; rubber cup polishing; topical application of anticariogenic agents, ie, fluoride; and selected orthodontic dental assisting duties.

We strongly recommend that these duties be recognized in a similar fashion as the current PDA duties and not left in the public domain. Dental assisting is a technical job and there must be a fundamental core knowledge for all those who seek expanded dental assisting responsibilities.

2. That the Royal College of Dental Surgeons of Ontario continue to list expanded-duty dental assistants such as the listing of PDAs under the current regulation. We believe this is a natural working relationship between the dentists and dental assistants of the province of Ontario.

1550

The Chair: Thank you very much for your presentation.

Mr J. Wilson: I get the impression you have a good relationship with dentists and the royal college. Is this somewhat of a wish list in recommendation 1? Which of these acts are you doing and not doing now?

Mr Miller: Basically, it is more of a revised list than a wish list per se. Right now, most of those duties are covered under regulation 447, section 49. There are a few other contentious subjects that have already been included in other provinces. Although the training is not here, it is a national norm list.

Mr J. Wilson: Have you wanted to be regulated as a profession at some point?

Mr Miller: We did approach the first Health Professions Legislation Review group of people and we were deleted after the first—

Mr J. Wilson: You did not meet the criteria?

Mr Miller: We did not.

Mr Beer: In terms of the education that the certified dental assistants receive right now, where do you receive that training?

Mr Miller: Actually, it is outlined on page 3, the appendix, dental assisting education. Most would be college grads of some nature. Most dental assistants do receive vocational education.

Mr Beer: So would that be where, for the expanded programs, you would see an expansion in the community college programs for dental assistants, or are you seeing that done through some other body?

Mr Miller: There are 26 programs that are community-college-based, publicly funded programs that train dental assistants; 11 of them are in the province of Ontario and they do not have extended functions.

Mr Beer: What surprises me is that you have to go out of the province for a number of these programs. Upon whom must you bring pressure to have more programs for dental assistants? Have the government or the colleges been refusing to expand their programs for more of these?

Mr Miller: In fairness to all involved, a great deal of what the government will do, I guess, relies very heavily on what comes out of the review of the health disciplines and, subsequent to that, they will train people for the new regulation. We just do not want to get lost in the shuffle. Right now, we are covered under a regulation that we would like to see enhanced, and we see an appropriate recognition of education.

Yes, it would be very nice to get this up and running. If the Ministry of Health would give the Ministry of Colleges and Universities the green light I am sure we could have this.

Mr Hope: Most presentations that we hear talk about stopping the ability to do the job. You put a lot of emphasis on education, but with the legislation that is being introduced and we are reviewing, will you be stopped from doing the job you normally perform?

Mr Miller: I would assume we would probably be doing more, based on the way it is going. The fact is, dental assisting has not really changed that much probably from the birth of the ODNA back in 1939, and it would be ideal to have some sort of recognition of education and then provide the education through the regulation of dentistry. That would be where we are coming from.

Mr Hope: To further elaborate on that, as I listened to your comments to Mr Beer, are you running into a roadblock with the ODA, trying to get these education programs? Is that why you are seeking our assistance in making sure it is in the legislation?

Mr Miller: The Ontario Dental Association?

Mr Hope: Yes, the ones you have been lobbying—

Mr Miller: Absolutely not. We have received nothing but support. There has been no lack of support from the dentists of this province. I have a survey in front of me that indicates on a province-wide basis—and this was done in conjunction with the Ontario Dental Association—the large majority of dentists want their auxiliaries to have this opportunity.

Mr Hope: I posed that question because you said a lot of them get their education outside the province of Ontario.

Mr Miller: This is sort of new. The legislation sat for an awful long time before the Royal College of Dental Surgeons commenced listing people. That is why we have Toronto people going to Prince Edward Island for education.

The Chair: We appreciate hearing from you. If you have any further information at any point, please feel free to communicate with the committee in writing.

1600

ONTARIO HERBALISTS' ASSOCIATION

The Chair: I call on the Ontario Herbalists' Association. All members have received a copy of your brief. Please introduce yourselves to the members of committee and try to leave a few minutes for questions at the end. You have a total of 20 minutes for your presentation.

Mr Stelling: My name is Keith Stelling. I am a member of the board of directors of the Ontario Herbalists' Association and a member of the National Institute of Medical Herbalists of Great Britain where I did my training. I am here to show you something about herbal medicine and the importance of medical plants as part of our complementary health system in Ontario.

The use of herbal medicine goes back for thousands of years. We have documents dating back to the year 2500 BC with the Georg Ebers papyrus, an Egyptian record of medicinal plants numbering some 750 plants that are still used today by medical herbalists. You see one here you recognize of course—hypotensive, lowers blood pressure; another one, the pine, which was used as a bronchodilator and is still used for the same purposes today; and another one, the birch, which was also discovered quite independently by our own native Canadians.

The important point about this is that these plants were discovered in different parts of the planet at different times in history.

In Canada, our own record of herbal medicine was first committed to paper by Jacques Cartier in the winter of 1525. The French of course were not experienced with our harsh winters, and the expedition which had been sent out by the King of France became marooned in the ice on the St Lawrence River. Fortunately, when the crew was struck down by a plague—they called it *la grande maladie*—there was a group of friendly native people nearby at the village of Stadacona who presented Cartier with a medicinal plant. It was this one, the *thuja occidentalis*, or the white or yellow cedar. Cartier's rapture about the recovery of the crew was quite outstanding.

There are a great many aspects to herbal medicine. You cannot see very well on this diagram, but you may recognize

some benzene rings if you have studied chemistry. In some plants, there are over 178 different medicinal constituents. The similarity between the human cell, with those squiggly things known as mitochondria, and the plant cell—you see the "M" labelling mitochondria again in the plant—represents the difference between the soft medicine, or the natural remedy in the herbal preparation, and the chemical drug.

Some of the amazing things we have discovered since Cartier's time, with the harsh light of modern scientific examination, is that plants such as this one, *calendula officinalis*, are actually antiviral in character. They have been shown in some of the institutes of phytotherapy in Europe to inhibit the spread of cancer or to inhibit the metastasis of cancer cells.

1600

Another very famous one is this one, *carduus marianus*, or the milk thistle, which is actually a restorative for the liver and has been used to prevent the effects of carbon tetrachloride in liver sclerosis.

Another one, *valeriana officinalis*, or valerian, is a natural tranquilizer which does not interfere with the functioning of the mind, as most of the drugs do, and this very famous one, *echinacea angustifolia*, actually boosts the immune system. That is a very important remedy these days with AIDS around. It has also been shown to be effective against certain types of human carcinoma, including the Walker carcoma carcinoma 256.

Here is some of the work of Dr Paul Velaiche, who holds the first chair of phytotherapy at the University of Paris in France. Dr Velaiche takes samples from his patients and cultures them on Petri dishes such as these, and then he applies the essential oils of aromatic plants. He has found very interesting antibiotic activity among some of these labiate family plants. The interesting thing here, and in the hospitals in Europe where this has been used, is that there has been no resistance to this form of antibiotic activity.

Another way that herbs work is to work through the glands of the body; here a lymphatic cleanser, *galium aparine*, which is very important as a conjunction in other diseases, especially in cancer, where you are draining the glands and taking away the waste from the body.

The Ontario Herbalists' Association is the oldest body of consumers and practitioners in Ontario. It has recently introduced a code of ethics for its professional members and this autumn will begin examining all its professional members with a stringent two-hour examination as well as an oral examination in adherence to the code of ethics. There is a lot to be done in training in Canada. We are really backward. We are behind the Europeans, who are now demanding a three-year full-time course for the standard of practising herbal medicine in Europe.

One of the important functions of the Ontario Herbalists' Association in guiding the public towards herbal remedies is the educational facility. Here you see one of their herb walks or field trips. They also present a number of lectures in Toronto and throughout the province.

I mentioned in this brief that you have before you the plant dandelion, *taraxacum officinale*, a very important liver restorative. It has been shown to be capable of extracting heavy metals from human tissues, which is a very

important aspect. Dandelion, of course, is a very safe diuretic. The leaves work on the kidney and it can be used in any quantity, but if you were, for example, to use this plant, *convallaria majalis*, you would find that if you went more than five mls of the tincture, that is, a teaspoon, spread out over a whole week, you would probably cause death.

The point of this is that some plants are very beneficial but dosage is critical. Can we rely on the medical profession now, which no longer has any training in medicinal plants, or pharmacists to be making such decisions? We are also leaving these things in the health food stores, without any labelling, and health food store proprietors are forbidden to advise customers on the use of the plants. As a result, people tend to self-medicate with medicinal plants. They are very powerful in some cases.

Here you can see *tanacetum parthenium*, or feverfew. Feverfew has been shown at the Glasgow Royal Infirmary in Scotland to be effective in a clinical trial for 70% of the patients suffering from migraine headaches. In 70% of the people, that will eliminate the migraine or cut down the frequency or the severity. This is an important aspect of the economic importance of herbalism.

We do not want to take these plants off the market, because they are saving time in loss of hours from the working place and they are also preventing long-term, chronic illnesses. But just like *tanacetum*, this one, *hydrastis canadensis*, another native of Canada, if used in pregnancy, can cause stimulation of the uterine muscle, which will cause abortion. Therefore, there must be more labelling on these products.

The British and the Europeans have a very important training program. The National Institute of Medical Herbalists of Great Britain trains people for four years in a full-time course which includes all the usual medical subjects, such as pathology and physiology and differential diagnosis. Here you see one of the training clinics and here you see one of the study gardens, with the plants laid out in ordered beds, a very important aspect of identifying plants before you use them. In Canada there has been some attempt to upgrade the training programs, but there is not enough and encouragement needs to be given both in public education and also in training of practitioners.

One of the points I want to make in this brief is that there has to be a difference between the term "drug," as referring to a chemical pharmaceutical, and a plant or a medicinal natural source, which cannot very adequately be administered by an orthodox or conventional practitioner.

Another point I want to make is that the use of inhalation has been taken away in the bill before Parliament and inhalation is a very important aspect of herbal medicine.

Here you see the eucalyptus tree. The eucalyptus is one of the plants which works as a bronchodilator on the human body and is a very helpful remedy in asthma, as is this one, *melissa officinalis*, or lemon balm, and again chamomile, and chamomile has always been used for children because it is so gentle, but we do not want to be lost from these ordinary household remedies. You may recall friar's balsam somewhere in your experience.

The other point which we are not clear about is whether we are being excluded from giving information on

nutrition. With the Dietetics Act, it looks as though herbalists may no longer be able to advise people on the use of food as part of a medicinal therapy.

I have here a copy of the book by Dale and Applebe, *Pharmacy, Law and Ethics*, which was the British solution to this problem. You see at the last of the brief some explanation of how the British have handled the dilemma with the 1968 Medicines Act, by grouping a number of plants which are dosage-critical to be administered only by trained practitioners or by pharmacists, and the others for sale over the counter in health food stores. I think we also need more adequate labelling on these remedies. Also I have here the other standard textbook for herbal medicine, the *British Herbal Pharmacopoeia*. A new edition has come out since 1983, but this lists all the herbs with their constituents and their activities.

You can see it is a fairly complicated business and I would like your support in helping us together to unravel the dilemma that is presented to us. Are there any questions?

Mr Grandmaitre: My question is not about herbal medicine or herbal treatment. What about our environment? Apparently we are losing our natural environment daily, and I am sure some of the plants you have referred to in your slides are being affected by our environment, acid rain, carbon dioxide and so on and so forth. Do you know if you are losing some of these very important plants that are in use?

Mr Stelling: Yes. Of course we are all losing, and we are losing the quality of the nutritional value of our food because the fertilizer that is being put on the fields is a chemical and we are not getting the ingredients that were once apparent, certainly before the war. Things just are not there. The other aspect is that herbal medicine is environmental medicine. We are not polluting. We are not releasing chemicals into the atmosphere.

Mr Grandmaitre: No, I did not imply that.

Mr Stelling: Exactly, and that is an important aspect of it. It is a renewable resource. It does not depend on multinational corporations, and some of the Third World countries have found this as well.

We are also losing species right here in Ontario. We are losing *hypericum perforatum*, which is actually being partly eliminated by a program undertaken by the federal government and the previous provincial government to control it with the chrysolina beetle, and that is being wiped out wholesale. But we are losing many others because of automobile pollution and a group of urban centres, this sort of thing.

1610

Mr Grandmaitre: Does that mean that if we are not concerned about the environment or become more concerned, you people will be out of business in 10 or 15 years?

Mr Stelling: I do not think it will be 10 to 15 years. Many people are concerned and many people are attempting to cultivate these plants. That is another important aspect of our work, recognizing them and making sure there is an adequate supply.

One of the plants I showed you, *hydrastis canadensis*, was once harvested in Ontario and one of the Indians at the

reserve near us in Brantford remembers her mother, who was also a herbalist, showing her a dump truck full of the root of this plant being taken away from the reserve.

So we have to think ahead. We have to think about these very important renewable resources. We have to think about the aspect of the gentle plant remedy being important when we get into difficulties with the side-effects of the drugs, which is increasingly happening.

Mr J. Wilson: It is very interesting. I gather from your brief and your comments that Bill 43 and the acts may put you out of business in some aspects of your practice. Were you involved in the review process at all? Were herbalists involved in making their concerns known to the Ministry of Health?

Mr Stelling: Not very much, no. We presented a number of petitions and briefs to Elinor Caplan and we received just about no replies, I think, right through.

Mr J. Wilson: How many practising herbalists are there in the province, for instance?

Mr Stelling: There are at least 20, but there are many who are practising herbalism along with another form of therapy. There are over 440, I think, consumer members of the Ontario Herbalists' Association and that has grown from 100 two years ago. There is a great interest on the part of the public.

Mr J. Wilson: I know there is some growing interest in my own riding, for instance, and among consumers. I am not aware at all what the legal status now in some of your practices might be. Are you recognized in any of the health acts now?

Mr Stelling: No, there is no recognition for herbalists, and as far as we understand, we are allowed to practise as long as we do not commit any of the forbidden acts. However, we are a small group and we have never had a college or any sort of self-regulation. Our efforts recently to get people accredited professionally, I think, are the first steps in that direction.

Mr Wessenger: I would like to call on the staff to clarify on this matter.

Ms Bohnen: It is not our view that this legislation will put herbalists out of business. First of all, the provisions dealing with the sale and distribution of drugs are the provisions of the Health Disciplines Act, which is not being amended by this legislation. This legislation primarily, of course, regulates pharmacists and others who prescribe drugs. It does not alter in any way the definition of "drug" currently used in the Health Disciplines Act. Entry to the marketplace, in Canada, of drugs and substances which are categorized as drugs is primarily a federal responsibility. This legislation also does not restrict who may provide counselling services to individuals. So it is not our view that this will have an adverse effect on herbalists.

Mr Stelling: I think the concern of the herbalist is that the administration of drugs in this document is under the control of the College of Physicians and Surgeons. We do not know whether ultimately, if there is some animosity against these non-licensed practitioners, the tide could go against us that way and we would like to see some form of protection.

Mr J. Wilson: I think you also said many of your remedies are not really included in the definition of "drug."

Mr Stelling: That is the whole enigma in Canada at the moment. Is a substance a drug or is it a food? There was a special advisory committee convened by the federal government and its findings put herbalism in a separate third category. We would like that result to influence your own work here.

Mr J. Wilson: Do the Ontario statutes use the same definition of "drug" as the federal laws?

Ms Bohnen: Yes. I think Mr Burrows could add to what I can say about this.

Mr Burrows: Yes, in Ontario there is a definition of "drug" in the Health Disciplines Act and it is compatible with federal legislation. Herbal remedies have always been a relatively grey area under the law, and with all due respect it would appear to me there are two issues here. One is herbalists as a profession or as a group of professionals regulated or unregulated, and the herbal remedies themselves. Some herbal remedies are drugs by definition. A good example that is well known is digitalis, which requires prescription in the province of Ontario—in Canada for that matter. It is also true that many of the remedies that are available have fallen into disuse. It is equally true that things have a way of coming around again, and whether they are used as herbal remedies or drugs are extracted from the natural source products, there is certainly still a future for those sorts of products.

But the issue here needs to be clarified as to what the association perhaps is looking for. If it is looking for recognition of herbs in some sort of special category, then we control the conditions of sale here in Ontario, but the basic proof of safety and efficacy is the responsibility of the federal government, and with respect, I would recommend that the direction be there. If on the other hand the concern is how the pharmacy part of the Health Disciplines Act currently—which I would point out is administered by the college of pharmacists, not the College of Physicians and Surgeons of Ontario. If there is an issue there, then that section of the existing Health Disciplines Act is not being altered, as Linda pointed out, by this package. It is in fact being left intact and renamed. I suppose it is conceivable that at some point the Legislature might want to look at that particular package of legislation and its relationship to this issue. With respect to the regulation of a profession, then the advisory council, perhaps under this legislation if it is passed with the advisory council intact, might provide an opportunity for dealing with that issue.

Mr Cordiano: I was simply going to say that you have made some good suggestions. In so far as it impacts on what we are doing here, I appreciate there is some question whether we have jurisdictional responsibility for that. But you make some good points with respect to safety of some of the medicines currently on the market, and I am quite concerned about that. Just a personal note, some of the recommendations you have made should probably be brought forth at the federal level, as appropriately pointed out here. That would be something your association should bring forward.

The Chair: Thank you for your presentation before the committee. The committee will reconvene tomorrow morning at 10 am. I want to thank all of you for attending today.

The committee adjourned at 1619.

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Official Report of Debates (Hansard)

Wednesday 14 August 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mercredi 14 août 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 14 August 1991

The committee met at 1000 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ONTARIO PHYSIOTHERAPY ASSOCIATION

The Chair: Good morning. I would like to welcome you all here this morning. We are going to begin with a presentation from the Ontario Physiotherapy Association. I ask that you leave a few minutes for questions from committee members following your presentation. You have 20 minutes. Would you begin now.

Ms Brien: Good morning, Madam Chairman, committee members. My name is Heather Brien. I am president of the Ontario Physiotherapy Association. Currently I work as a physiotherapy supervisor in the rehabilitation department of Women's College Hospital here in Toronto. With me are Marel Fielding and Signe Holstein. Marel Fielding is past president of the association and the current chairman of the association's RHPA committee. Marel is manager of physiotherapy services at University Hospital in London, Ontario. Signe Holstein is executive director of the association. Signe has worked as a physical therapist, as an educator and as a manager of physiotherapy services for 23 years. The Ontario Physiotherapy Association represents the majority of practising physiotherapists in Ontario and is part of the Canadian Physiotherapy Association.

Physiotherapists, or physical therapists, practise their profession in hospitals, nursing homes, homes for the aged, schools, industries, the community and in private practice. The practice of physiotherapy has evolved over the years in response to the advances in medical knowledge and technology and to the needs of the population of the province. There has been, and continues to be, an increase in demand for physiotherapy services. The greying of the population, the public's involvement in sports-related activities and fitness, and medical advances such as transplantation techniques have all contributed to this demand.

Physiotherapy is a leading health care discipline in rehabilitation services. Physiotherapy is a key to mobility and independent lifestyle. Physiotherapy works in partnership with a patient to achieve the best results, be it relief of pain, moving joints, strengthening muscles, learning to function after major surgery or accident, dealing with chest or heart

problems and so on. Should complete relief of pain or return to normal function not be possible, the goal of treatment would involve development of techniques to enable the patient to live with the restriction imposed by the disease, disorder or dysfunction. As well, physiotherapy intervention includes teaching a patient how to prevent recurrence.

Apart from medical doctors and nurses, physiotherapists are unique in that they can intervene throughout a patient's life cycle at any stage of the disease process, from critical to chronic, and in institution, clinic or home settings. For instance, you may come in contact with a physiotherapist in a neonatal intensive-care unit working with premature infants, in a coronary care unit following bypass surgery or in long-term care and palliative care setting.

Physiotherapists are university-educated and -trained and receive their education at one of five universities in Ontario: the University of Toronto, the University of Western Ontario, Queen's University, the University of Ottawa and McMaster University. The programs are usually four-year honours leading to a bachelor of science physical therapy degree. Included in the educational program is a component of a total of seven months of clinical practice.

On behalf of the association's 3,300 members, I would like to express our general pleasure with the proposed legislation. Physiotherapists are pleased by the proposed act's recognition of physiotherapists as primary care givers. We are also pleased by the suggested amendment to Bill 62, the Physiotherapy Act, that adds the controlled act of tracheo-suctioning, a procedure currently performed by physiotherapists that was apparently overlooked in drafting the legislation.

The Ontario Physiotherapy Association has three outstanding concerns that are extremely important to the practice of physiotherapy. All three issues could be resolved without much difficulty. The issues are, first, protection of both our profession's equally valid professional descriptors, "physiotherapist" and "physical therapist"; second, matters dealing with the controlled acts of diagnosis, communication to a patient the cause of his disease, disorder or dysfunction; and third, performing procedures below the dermis.

I will have Marel Fielding address our concerns related to title, Signe Holstein will address our position on the matter of diagnosis and I will conclude with the procedures below the dermis.

Ms Fielding: Members of the public must be able to identify different health care providers. This is the cornerstone of consumer protection in the proposed legislation and in the regulation of the province's health care professionals. It assists patients to make informed choices. The Physiotherapy Act proposes to protect the title "physiotherapist" but not "physical therapist." Since both terms are uniquely associated with the profession, we believe this will be confusing to the public.

One of the fundamental processes of the Health Professions Legislation Review was to protect the consumer from unlicensed, untrained and unethical practitioners who would hold themselves out to be something they are not. In Ontario and indeed in all of Canada, physiotherapists are known equally and interchangeably as physical therapists. Most physiotherapists graduate with a degree in physical therapy. The terms "physiotherapist" and "physical therapist" are protected under our current legislation and are protected titles in seven out of nine other provinces. To us and to most health care providers, the terms are synonymous.

Accordingly, we believe it is essential, in order to protect the consumer, to prevent confusion and be consistent with current practice, that the terms "physical therapist" and "physiotherapist" be protected titles under the new legislation. We believe that Bill 62, the Physiotherapy Act, should be amended to insert "or physical therapist" wherever "physiotherapist" occurs.

Ms Holstein: Equally important to the current and continuing practice of physiotherapy is the issue of communication of a conclusion identifying a disease, disorder or dysfunction. This act, which we refer to in shorthand as the act of diagnosis, has been replaced under the proposed regulated Health Professions Act as a controlled act defined as, in short, "communicating a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms...in circumstances under which the patient can reasonably be expected to rely on the conclusion."

Our code of ethics and rules of conduct state that "a physical therapist...must give the client or surrogate the opportunity to consent or decline treatment" based on "the physiotherapist's objective findings, clinical diagnosis, treatment plan..."

Physical therapy diagnosis is not merely a description of symptoms; it is a conclusion relative to a disorder or dysfunction. We do not diagnose disease entities, nor do we wish to do so. However, physiotherapists regularly communicate the conclusions as a result of evaluation identifying the cause of the disorder or dysfunction. To correct this oversight, the Ontario Physiotherapy Association recommends an amendment to the wording of the Physiotherapy Act that would allow physiotherapists or physical therapists to communicate a conclusion identifying a disorder or dysfunction as the cause of symptoms. This amendment is consistent with physiotherapists' primary care status under the legislation, with our education and with patient expectations.

Ms Brien: Our last concern relates to a controlled act that has not been included for physiotherapists under this new legislation, and again, the omission would have significant impact on the practice of physiotherapy. In question is the controlled act of performing a procedure beyond the dermis. Physiotherapists do not perform surgery, but we do, for instance, perform escharotomy in the management of burn patients. In plain language, we remove dead tissue from burn sites to allow new skin to form and tissue to heal. Physiotherapists also remove sutures and K-wires in some treatment situations. These procedures are an integral part of physiotherapy treatment in specialized settings.

To correct this, the Ontario Physiotherapy Association recommends the inclusion in the proposed Physiotherapy Act, having limited controlled acts allowing physiotherapists to perform certain procedures beyond the dermis.

Physiotherapy is a vital part of health care delivery in this province. The demand for physiotherapy is increasing and will continue to increase with the greying of the population. We ask you to help ensure that consumers of physiotherapy services benefit from our training and are able to make informed choices about treatment by attending to our three concerns: (1) protection of our two equally valid titles, "physiotherapist" and "physical therapist"; (2) permission for us to continue to communicate a conclusion identifying a disease or disorder as the cause of symptoms; and (3) inclusion in our scope of practice the controlled act of performing a procedure beyond the dermis. Thank you for your attention. We would now welcome your questions.

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Mr Beer: Thank you very much for your presentation and setting out clearly the concerns that you have. With respect to the title "physical therapist," what arguments were you given as to why that should not be protected as well? I think you mentioned in your brief that seven provinces have that.

Ms Fielding: I think it was an attempt, which we agree with to a degree, that the act should be kept as simple and clear as possible. They would really like to protect only one title for each profession. For us that is very difficult because both the terms are used interchangeably all the time. They mean the same thing to us and we think it would be very confusing.

Mr Beer: In terms of the other people who may use that, is that a problem right now? Am I right that it is protected now?

Ms Fielding: Yes, it is protected under the Drugless Practitioners Act.

Mr Beer: If you discover, say, a kinesiologist who is using that title, then you can have that person stopped, is that correct?

Ms Fielding: Yes, our board of directors, the current regulatory body, would send them a cease and desist letter.

Mr Beer: Does that happen very often in the present situation?

Ms Fielding: Not so often, but it is happening. They are suggesting that they are physiotherapists.

Mr Beer: Does that tend to be more from ignorance than wilfully doing that? I am calling for a conclusion which I should not do.

Ms Fielding: I could not really answer that one.

Mr Beer: Okay, that is fine. Thank you.

Mr J. Wilson: I am just wondering, in not allowing you the authorized act to perform procedures below the dermis, was that an oversight or are you saying it is current practice? Did the review committee consider it and turn it down or is it just an oversight, you figure, on its part?

Ms Holstein: We have discussed that particular issue at some length and have particularly discussed the concep

of a limited controlled act. There are some concerns about the level of that limited controlled act and we did not reach any consensus on that.

Mr Hope: Just dealing with some of the comments about jobs you already do, in particular dealing with removal of the stitches, is that not normally performed by the nursing profession more than—

Ms Fielding: It could be. I think it is the kind of situation where the physiotherapist would be working as a member of a team. It could be a nurse, an occupational therapist, a physiotherapist or a physician.

Particularly now, when a lot of patients are being sent home perhaps to a remoter community, the home care people might be sending in several different disciplines. It could be the physiotherapist, and if it is the opportune time to do it the physiotherapist would do it. It just would depend on whichever professional was working with the client that day when it was due to come out, and that professional would do it.

Mr Hope: Would you not need a medical analysis of why something has gone wrong in the surgery itself or why the infection has grown?

Ms Fielding: These are very routine things. Of course the client would be sent back to the physician to review it if there was an infection or something. But these are routine things, not infections and so forth.

Mr Hope: You would not be making a diagnosis of the—

Ms Fielding: We would be coming to a conclusion and perhaps sending it back. We would be making a diagnosis but we would not communicate it. We would send the patient back to the physician.

Mr Jackson: I want to return to your first concern. If the legislation is passed in its present form, that means we would have no legislation governing physical therapists. This legislation exists in seven other provinces, I understand? Is the distinction strong enough between the two? What, in your opinion, would occur for people setting themselves out as a physical therapist without any regulatory guidance?

Ms Fielding: There really is no distinction in our minds between the two. What we could see happening is that perhaps people coming in from the United States who are physical therapists in the United States could, I suppose, practise without being regulated by our college, because the college would only regulate physiotherapists.

Mr Jackson: In Ontario, then, there is not the distinction in your mind, but in other jurisdictions there is a distinction.

Ms Fielding: There is no distinction. I think it is just a different terminology. In the US they use "physical therapist." In various different countries across the world they use "physiotherapist" and "physical therapist" interchangeably. The British term is "physiotherapist," the American term is "physical therapist." It is scattered. The World Confederation for Physical Therapy uses the term "physical therapist." It is too hard to translate. Some of them translate better one way or the other.

Mr Jackson: I think I understand that better. Thank you.

The Chair: Thank you very much for your presentation. We appreciate your coming before this committee this morning.

INTERIM REGULATORY COUNCIL
ON MIDWIFERY
CONSEIL INTÉRIMAIRE
SUR LA RÉGLEMENTATION
DE LA PROFESSION DE SAGE-FEMME

The Chair: I would like to call next the Interim Regulatory Council on Midwifery and ask that you come forward and begin your presentation by introducing yourselves to the committee. You have 20 minutes for your presentation and we would ask that you leave a few minutes, if you will, for questions from the committee at the end of your presentation. Thank you very much. Please be seated. Your time begins now.

Mme Eberts : Mesdames, messieurs, nous sommes heureuses de venir ce matin vous présenter le mémoire du Conseil intérimaire sur la réglementation de la profession de sage-femme au sujet des projets de loi 43 et 56, qui sont si importants pour l'intégration des sages-femmes dans le système de santé de l'Ontario.

Je m'appelle Mary Eberts ; je suis présidente du conseil. Je ne travaille pas comme sage-femme, mais comme avocate. Ma collègue, Wendy Sutton, est une des représentantes des consommatrices au conseil et fait aussi partie de son comité de direction.

The Interim Regulatory Council on Midwifery was created by order in council under the Ministry of Health Act in May 1989 to act as an advisory committee to the Minister of Health on such matters as the development of standards of practice and the establishment of criteria for certification of midwives in Ontario. The order in council sets December 31, 1991, as the sunset date for the IRCM. We hope that this timing will mesh closely with the proclamation of the Midwifery Act and establishment under that act of a transitional council for the statutory College of Midwives.

There are 13 order-in-council members of the IRCM, drawn from health care and other professions and from consumers. None of the order-in-council members are practising midwives.

Since its outset, the IRCM has had a liaison committee appointed by the Association of Ontario Midwives. It consists of nine people, and the 13 order-in-council members and the nine midwife members of the liaison committee have worked closely over the past two years. We believe that our experience in working together, both midwives and non-midwives, should bestow great confidence on those who think that greater public involvement in professional governments will have negative consequences. The midwives, to whom the initial stages of their profession are so important, have worked very helpfully and very well with us in this unusual arrangement. To them goes great credit, and I believe that the experiment we have been involved in shows the wisdom of the Regulated Health Professions Act in including more consumer and non-professional representation on the governing councils.

Although there are consumers among the order-in-council appointees of IRCM, the council has also established a structure to facilitate regular contact between the IRCM and the Midwifery Task Force of Ontario, a major consumer group. Their participation as observers and in regular meetings with us have greatly strengthened our work at the council.

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At its inception, the IRCM set up four standing committees. The standards and qualifications committee has developed a number of standards and guidelines, which have been discussed and approved by the council as a whole. These include: a statement of philosophy of midwifery care in Ontario; core competencies; a code of ethics; indications for mandatory consultation and transfer of care; laboratory testing and diagnostic imaging; and a statement on home birth. Toutes ces déclarations de politiques et de philosophie sont disponibles en français et en anglais. Vous les trouverez dans le petit livre de documents qui accompagne notre mémoire.

Le comité sur la législation et sur l'éducation du public a publié deux rédactions de la Gazette et un bulletin bilingue qui est largement distribué dans la province. It has met with the professional associations and governing councils of the other health care professions and established working relations with them, has participated as a member of Inter-health and engaged in various public education activities throughout the province in both English and French, including video programs which are available across the country.

The bylaws committee has drafted a working paper for the operation of the IRCM and is responsible for drafting the bylaw structure for the proposed College of Midwives.

The equity committee is, we believe, something of an innovation in professional governance, and something of which we are very proud. The IRCM and liaison committee wished from the outset to ensure that the profession and its governing body are responsive to different groups who are interested in midwifery as a profession or as a service. The equity committee was created to help us achieve this aim. It has undertaken extensive consultation and visits: in St Jacob's in southwestern Ontario, to learn firsthand how a rural area with a large Mennonite population has developed family-based midwifery care; with native communities in northwestern Ontario, to discuss their traditional practices and explore with them the impact of regulation, and with various groups in eastern Ontario. The committee is currently directing its attention to different cultural groups within the urban core of southern Ontario. These consultations, and the committee's other research, have broadened and enriched the perspective of the council in important ways.

You will also find in the brief of documents our brief to the Public Hospitals Act committee, with respect to which my colleague will have further comments.

In addition to its own committee work, the IRCM has worked closely with the curriculum design committee and the midwifery integration project planning committee set up by the Ministry of Health. We have endorsed the submissions of the CDC to government, a summary of which is in our brief of documents, and the work to date of the

MIPP, in connection with which our work on core competencies was done. We look forward to reviewing the final report of the MIPP at our August meeting.

Parenthetically, I might add that among the recommendations of the CDC, which we endorsed, was the proposal that midwives qualify in Ontario by pursuing a baccalaureate program at the university level. We also endorse the recommendation of both the Task Force on the Implementation of Midwifery in Ontario in 1987 and the MIPP that there be a pre-registration program to facilitate the integration of current practical midwives into the profession.

The IRCM meetings are held in public on a regular basis. In our first year, we had 10 meetings. This year, with an increased workload in the committees and the same budget, we had to cut back to eight meetings. A schedule of meetings is published in advance, and upon prior notice, the IRCM will provide French-language translation services to members of the public who request them.

In our use of French, the IRCM reflects its commitment to the spirit as well as the letter of the French Language Services Act. This commitment is an important part of reflecting the diversity of Ontario.

Par conséquent, nous traduisons non seulement les déclarations de politiques et de philosophie ainsi que la Gazette, mais aussi les procès-verbaux des réunions publiques du conseil et des mémoires comme le présent. La vice-présidente et l'une des membres du conseil sont francophones, et la présidente, comme vous pouvez le voir, ne fait que des efforts.

Native midwifery has been an important concern of the IRCM since its inception. The equity committee has given priority to establishing liaison with native groups in northwestern Ontario, and its activities have included consultations in several native communities. We are therefore very pleased that native organizations have stressed the importance to them of having community control of midwifery and input into its governance and have begun to meet with ministry officials on these issues. We support this consultative process and believe it should lead to a great accommodation of the distinct traditional values and practices of the native community.

The Interim Regulatory Council on Midwifery has reviewed both the Midwifery Act and the Regulated Health Professions Act, and we support the legislation and its focus on public protection, public representation and consumer choice. We are pleased too that the protected title in the legislation is "midwife." In our experience, consumers refer to their midwife as a midwife, not as their registered midwife. The generic title will also prevent the unfortunate growth of two professions, one called registered midwife which operates within a statutory framework and one called midwife which operates outside it, a bifurcated profession, which has unfortunately been the result of legislation in several American states.

Successive provincial governments have clearly supported the introduction of legislation after having widely consulted both consumers and health professionals across the province. We believe that Ontario has some catching up to do, as Canada is one of the few World Health Organization countries and one of the few industrialized countries

in the world that does not recognize midwifery, but are pleased that Ontario is taking the lead in this. We believe that the integration of midwifery into the Ontario health care system reflects current trends towards community-based care and consumer choice of care giver and reflects the increased desire of women and families to experience pregnancy and birth as normal, healthy physiological processes.

Let me turn to my colleague now for some comments on the amendment.

Ms Sutton: The Interim Regulatory Council on Midwifery supports government motions respecting amendments to the Midwifery Act, specifically section 4, paragraphs 5, 6 and 7, regarding heel pricks on newborns, catheterization and prescribing.

In addition, the IRCM requests that the committee recommend amendments in order to allow midwives the right to start intravenous therapy and perform venipuncture. We understand the provisions in the act respecting emergencies would permit midwives to start intravenous therapy in the event of an emergency. However, in order for midwives to achieve a certain level of skill and maintain this skill level, it will be necessary for them to start intravenous on a regular basis, for example, in in-hospital augmentation of slow labour by means of intravenous.

We recommend that midwives be permitted to perform venipuncture because this addition will enhance the convenience of consumers and their access to continuous midwifery care, particularly in isolated areas. The ability to do venipuncture is particularly useful in the home birth situation for Rh testing and reassurance with regard to haemoglobin levels during post-natal testing. We are aware that in large urban centres a home birth mother who is registered with the home care program could request a laboratory technician to come in and do the venipuncture tests. However, this is not in keeping with the fundamental premise of continuity of care with which midwifery has been envisioned in Ontario, nor is it likely to be available for mothers outside of large urban centres.

With respect to the future of midwifery, since its inception the IRCM has been aware of the importance of the development of interprofessional relationships. This is especially true given that midwifery is new to the regulated environment. The distribution of controlled acts among the various health care professions will require all of the professions to develop co-operative, collegial relationships that are based on good faith and developed protocols. Through our legislation and public education committee, we have undertaken a course of meetings with the different health profession associations and governing councils. We have used our contacts to initiate consultations with the professions as we develop standards and protocols for midwifery. We intend to continue the development of these contacts in order to ensure the smooth integration of midwifery into the Ontario health care system.

We have also consulted with midwives and midwifery educators from a number of other countries on the issue of interprofessional relationships. These broader consultations inform our view that mutual respect is the hallmark and precondition for the success of the system of controlled acts. As the new and expanded health professions

embrace their responsibilities and rights under the Regulated Health Professions Act, the benefit to the consumer and the system will become obvious.

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We understand that midwives will work with doctors, registered nurses, registered nursing assistants, laboratory technicians, X-ray technicians, psychologists and other professionals. Depending on the practice sites, midwives will be involved in the management of facilities with these professions. We will be proposing to the new College of Midwives that regular consultation with these professionals be incorporated into its agenda on both formal and informal levels. While we recognize that for some of these professions the entry of a new primary care giver will require adjustment of traditional expectations and familiar working structures, we are confident that the midwife will soon become a valued member of the health care team all over Ontario, as she is already in some communities and settings.

Preliminary work has been done through the office of the midwifery implementation co-ordinator to describe practice sites. It is contemplated that midwives will practise in hospitals, hospital birth centres, independent birth centres, community health clinics, CHOs, HSOs, and domiciliary settings. We await direction from the ministry on the types of funding which will be available for midwives in these settings.

The IRCM ad hoc committee on the Public Hospitals Act has recommended to the Public Hospitals Act review steering committee that the act be amended to allow midwives to admit and discharge clients from the hospital. We believe that the original government intention behind the introduction of midwifery was to include midwifery practice in the hospital setting. Consequently, this amendment will be required coincidentally with the creation of the College of Midwives.

In conclusion, we are pleased to see the support for legislative recognition of midwifery and believe that the functions of self-regulation can be well carried out within the framework created by the bills you are reviewing, amended as we have discussed today.

In closing, however, we wish to urge the government and the Legislature as a whole not to assume that the establishment of midwifery as a regulated profession will be complete once these bills have become law. We still need the establishment of both the pre-registration and permanent education programs, the amendment of the Public Hospitals Act and the small amendments to various other statutes, development of a funding mechanism for midwifery service, and commitment to support institutional development or change that will see to the permanent establishment of the college and ease the integration of midwives into the health care system. We look forward to working with you on the completion of this important agenda.

Mr Beer: Thank you for your submission and also the material you have adjointed to it.

I sense from your presentation that obviously you have a couple of specific points you would like the committee to address in terms of possible amendments, but that on balance things have moved along, the council is going to

be established and there will be a real mechanism to direct midwifery in the future.

I wondered if you might just talk a bit about the education. You have mentioned things that you hope will happen, but how do you see the education of midwives evolving? What point are you at with the interim council or has there been able to be much work done on establishing a program and trying to find a place or places where it would be provided? I think you mentioned the university setting, but I just wondered where that was at.

Ms Eberts: There really are two aspects to this issue, and one is the pre-registration program for currently practising midwives. We have been working quite closely with the midwifery integration planning project, which is a consultative group set up and operated out of the Michener Institute to canvass opinion in the community and among the professions on how best to do that integration project. We have, through that collaborative work with them, developed our list of core competencies which we believe to be the foundation of both the pre-registration program and the baccalaureate program in midwifery.

You will find the core competencies in our book of documents which we gave you. We have one final discussion of the MIPP report to have at our next council meeting, which is this month. I expect that we will sign off on it then and it will go on to form the basis for the pre-registration program.

We essentially have no responsibility for running that program, but we have been very deeply involved in consultations with them because it is ultimately the transition college, which is our successor, which has to register all of the midwives who come out of that program. So rather than have them go through it and find that the college will not approve it at the end, we have been involved in the planning.

Mr Beer: Those who are part of the midwifery association or who are currently practising as midwives, would their background stem from another jurisdiction—Europe, Britain, the United States, or—

Ms Eberts: There is a variety of backgrounds. Some are trained at the university level from other jurisdictions. Some are trained through the regular program of training, whether it is university or not, in other jurisdictions. Some are apprentice-trained here or in other jurisdictions. The purpose is to require that all the midwives who are currently practising be evaluated according to a common core of capabilities. To the extent that any of them need upgrading, that will be done within the context of this program, so that all who finish the program will have reached the same level of competency as we will be requiring for the baccalaureate program.

The baccalaureate program, we hope, will be established on a collaborative basis. Certainly that is what the IRCM has been recommending: that the program take account of the geographical and social diversity of Ontario and be available on a very decentralized basis. Given the small size of the profession, we expect that more than one institution may have to be involved in delivering those programs. We have stressed that the baccalaureate is important because a new profession will have to be very capable and very confident in order to find a place in the

health care system, but that there be a very flexible approach to delivering that program, to recognize the cultural diversity of Ontario and to recognize as well that many people who will be interested in it will be people with established contacts in communities that they will wish to return to serve.

The Chair: A question, Mr Hope. One minute.

Mr Hope: Yes, just a brief one. A number of concerns have been brought up by the nursing profession dealing with midwifery in rural Ontario, and I would just like to know for myself, and maybe for the other members of the committee, the difference between what you do and what the nurses do in the delivery of a child.

Mr Jackson: In under a minute.

Ms Eberts: In under a minute, midwives accept ultimate responsibility in a normal delivery. Nurses work under the supervision of a doctor. Some of the comfort that is given, some of the acts that are given, may be the same in some circumstances. It is envisioned that the midwife will be the primary care giver, the ultimate acceptor of responsibility for saying what will be done with respect to treatment during the pregnancy, during the labour and during the delivery. That is an essential difference between midwifery and nursing. That is how midwives operate in other jurisdictions.

The Chair: Thank you very much, and thank you for your presentation.

1040

TORONTO BIRTH CENTRE

The Chair: I would like to call now Toronto Birth Centre. You have 20 minutes for your presentation. Welcome to the standing committee on social development. I would ask that you begin your presentation now and if you could leave a few minutes for discussion and questions with the committee members at the end of your presentation.

Ms Sutton: I hope you will view my change of seats as a symbolic change of hats. I think it is worth pointing out that one of the strengths of the reproductive care movement in Ontario is the active community involvement of many of us. So I think this bodes well and is a strength of both the IRCM and the Toronto Birth Centre.

My name is Wendy Sutton. I am a consumer member and the president of the Toronto Birth Centre. I would like to introduce you to the other members of the TBC who are with me today: Marianne Cheetham is vice-president of the TBC, a primary care nurse with the South Riverdale Community Health Centre, and a non-practising midwife; Robin Kilpatrick is a practising midwife and a board member of the Association of Ontario Midwives. We bring regrets today from Howard Krieger, who is uncharacteristically under the weather and unable to attend.

We are all members of the board of directors of the Toronto Birth Centre, and we would like to thank this committee for the opportunity to address it.

By way of background, the Toronto Birth Centre is an incorporated non-profit organization comprised of a group of parents, professionals and interested individuals whose goal is to establish a freestanding birth centre in Toronto.

We believe that women and their families deserve the choice of experience in childbirth in a setting where birth is encouraged to be a normal and healthy event. We believe that informed decision-making and a choice of care givers are essential rights of clients and that respect for each individual, self-determination and empowerment must be ensured.

We are committed to a model in which clients in the community are involved in all aspects of the management of the centre and we are committed to the pursuit of three main goals. Our goal of service will ensure the provision of a safe, satisfying and individualized birthing experience for women and their families. Our goal of advocacy will promote and support awareness of a healthy birthing alternative for both the public and the centre's clientele. Our goal of education will provide information and education in both formal and informal settings for the public, clients and birth-related professionals, supported by the development of a community birthing resource centre.

On behalf of the board and members of the Toronto Birth Centre we are here today to express our support for the Regulated Health Professions Act. The TBC was formed in 1979. Over those 12 years, we too have experienced "many turns, bumps and delays," to which the minister referred with respect to the RHPA before this committee on August 6. We applaud those who have worked so long and hard on this legislation.

In broad terms, we support the improved opportunities, increased roles and recognition that this legislation offers to women within the Ontario health care system. We support the goal of improved public accountability of professions through increased public representation on councils and discipline panels and through open hearings. We support the intention to improve public protection through implementation of a program of quality assurance and we support the broadened choice of care givers that this legislation proposes as demonstrated by the inclusion of Bill 56, the Midwifery Act. It is this portion of the legislation we wish to address in more detail today.

Since its inception, the Toronto Birth Centre has enjoyed the involvement and support of many midwives. Currently four members of our board are midwives and our board of advisers and general membership boast another dozen individuals who are also midwives. We have a philosophy which is compatible with that of midwifery in honouring continuity of care, informed choice, client decision-making and the appropriate use of technology.

As we approach the day in which we will see the first regulated midwives practising in Ontario in over 100 years, we recognize that birth centres and midwifery care go hand in hand. We are aware that the midwifery scope of practice will include a variety of settings for birth, with parents making informed choices according to their needs. Research shows that birth centres are the choice of many parents. Birth centres will also provide ideal locations for midwives in training and could provide efficient mechanisms for funding midwifery care within the community.

The availability of registered midwives as primary care givers in the development of a truly alternative birth setting will do much to enhance the quality of childbirth care for

women in Ontario. It is clear to us that the legal recognition of midwifery and the establishment of freestanding birth centres will benefit from co-ordinated implementation.

One of the greatest challenges emanating from the passage of this legislation will be the way in which professionals adjust to new working relationships. As this applies to reproductive care, we see the need for much dialogue and thought regarding the relationships of physicians, midwives and nurses. The Toronto Birth Centre has always been committed to the involvement of the disciplines of medicine, nursing and midwifery in its operation. As birth centres are developed, we will have the opportunity to develop a unique multidisciplinary model of alternative birthing care that would demonstrate teamwork and reflect consumer choice.

With respect to specific amendments, we would encourage support of the minister's proposed amendments to Bill 56, the Midwifery Act, paragraphs 4.5, 4.6 and 4.7, concerning maternal urinary catheterization, prescribing from a limited list of drugs and the taking of blood samples from newborns. We also endorse the amendments put forward by the Interim Regulatory Council on Midwifery with respect to venipuncture and intravenous therapy. All of these amendments are congruent with the scope of practice of midwifery and enhance client safety by providing continuity of care.

We are pleased to see the interest expressed by government in native midwifery. In keeping with our goal of providing educational opportunities, we have offered our assistance to groups considering the birth centre as one means of implementing midwifery care in their communities.

The TBC has reviewed the preliminary report of the task force on sexual abuse and has indicated support for its recommendations. We look forward to its submission here on August 28 and to the incorporation of its recommendations into the legislation.

We view the RHPA as the catalyst to opening doors to a full range of consumer choice in many areas of health, and in particular in the provision of birthing alternatives. Toronto Birth Centre looks forward to contributing to and being actively involved in that process. We welcome your questions.

Mr Jackson: I am trying to get a clearer sense of the previous deputant, who came to advance the general level of training and access—not necessarily access, but the general level of training and regulation for midwifery in Ontario. Yours deals as well with the issue of access and the environment in which midwifery can occur. In the absence of any changes to the Public Hospitals Act, what is the likelihood of the development of birthing centres, either associated with hospitals or freestanding? Are they existing now outside of a hospital setting? I did not think they were. And what is your level of access to those birthing centres that are associated with hospitals? We are not giving you the amendments to the Public Hospitals Act. What does that mean to the current practice? The first brief talked at length about how far we are not going as well, so now that I have an opportunity to ask some questions I would like to explore this area.

Ms Sutton: It is a complicated question. It has great historical roots to it as well. At present there are no existing

freestanding birth centres and there is clearly a philosophical difference between a freestanding birth centre and those that might function within a hospital.

Up until the last year, the last government had indicated it was going to go ahead with seeing the setting up of birth centres or expressing a proposal call for birth centres under the Independent Health Facilities Act. We are still awaiting some decision on the direction of that. Clearly there is some evidence that we see ourselves fitting more comfortably in more of a community health centre setting. Philosophically that is a little bit more comfortable.

I think from the standpoint of the incorporation of midwifery as a community-based profession as well, there is a comfort level too that is worth considering, but at the moment there are no existing birth centres in Ontario. We are certainly, after this length of time, anxious to see that happen.

Mr Jackson: As someone who sat on the independent health facilities public hearings and participated in the amendments and your presentations in that context, I was aware of the direction and the philosophy that you are pursuing. I am anxious to understand, though, why that legislation will not allow you or does allow you to proceed, whereas we are still hearing the call for the amendments to the Public Hospitals Act. Can you go into a birthing room as opposed to a pre-delivery room in a hospital? Do you have access to that or is that a mutual consent? I would like to get a clearer picture of what midwifery's operating procedures or impediments are currently in Ontario hospitals.

I am asking a second question here in the area of how you interface with the hospital birthing rooms, which are now growing in number in this province, and a lot of hospitals are expanding them. They are in my community, which we support. But I would like to know when a couple has decided to use midwifery services and wishes to have them participate in a birthing room, as distinct from an operating room or pre-delivery room environment. I do not understand what the relationship is there and I would like you to clarify that for me.

Ms Sutton: Let me first clarify that Toronto Birth Centre is based on the development of the facility outside the hospital setting and represents an interdisciplinary model.

Mr Jackson: I understand that.

Ms Sutton: From the standpoint, though, of midwifery—Robin, you might want to comment on that.

Ms Kilpatrick: Your question is, if this legislation went through and we did not have a Public Hospitals Act amendment, because right now—I answered this question last week about how midwives are currently working, and that is essentially as support people and advocates at this point, going into the hospital without any recognized role within the hospital. It is hard to imagine this legislation without those amendments and say how a midwife would then work in the hospital setting. If a midwife is acting as a primary care giver, you would envision that then she would continue providing primary care within the hospital setting, if we had those amendments, that the midwife would go in and provide care to her client within the hospital.

1050

Mr Jackson: Just one quick final question. To make it make it really clear in my mind, without the amendments, is it now possible for a hospital to deny you access to the birthing room? That is the straight answer I am looking for.

Ms Kilpatrick: I would say yes.

Mr Jackson: Yes. And that practice can continue in the absence of any amendments. That is your understanding. That is what I was trying to get at.

Ms Kilpatrick: I would believe so.

Ms Cheetham: It is bad PR, but they can do it.

Mr Owens: In terms of the access and cultural sensitivity issues, I am wondering if you have any recommendations that you could make to the committee on how we can, in drafting the regulations, ensure that cultural sensitivity is an issue, whether it is in the native Canadian communities or downtown in other communities, so that people feel comfortable with the experience, as is the intent of the legislation. With the excellent work that your group does, I am wondering if you have any recommendations that you could make to this committee in terms of directions or—

Ms Sutton: I think you have to understand that at the Toronto Birth Centre it is our intention to have every possible access to our facility available to any group, on cultural levels or whatever. That is very much a part of the philosophy of the Toronto Birth Centre.

With specific respect to native midwifery, I think is worth pointing out that although the cultural concerns, the specifics of a setting, say, of native groups compared to something like a Toronto Birth Centre group might vary considerably in their structure, there is no question that the concern for the conducting of childbirth with the surrounding choices that the Toronto Birth Centre and other birth centres want to make available to their clientele is common. The issues of choice in childbirth are common to groups like Native Midwifery and native groups in northern communities, ourselves and other groups across the province, so that we share the way in which childbirth is conducted as a concern, although our specific situations may differ from locale to locale. In that sense, we are unified in terms of having an access to everyone who wants this kind of choice in childbirth.

Mr Owens: Just as a supplementary, to the parliamentary assistant, I am wondering if there is any work going on at this point with respect to amendments to the Public Hospitals Act so that we get the tandem legislation so that these folks will not be in a position to be denied—

Mr Wessenger: I will have ministry staff answer that.

Ms Bohnen: There is an ongoing Public Hospitals Act review that I believe was established under the previous government, that has been continuing in consultation with representatives of the professions, including midwives. I do not know what the timetable of that committee is, but the desired outcome of its work is recommendations for amendments to the Public Hospitals Act.

Mr Owens: Some time within the term of this government, I presume?

Ms Bohnen: I cannot answer a question like that.

Mr Grandmaitre: As a follow-up, my question is now directed to the panel. Would you say that without the proper amendments Bill 43 has very little meaning?

Ms Sutton: Which amendments do you refer to?

Mr Grandmaitre: I am talking about the amendments to the Public Hospitals Act. Without those amendments, would you say that you have limited powers, and it means very little?

Ms Kilpatrick: That is one way of describing it, that it would definitely limit and interrupt what we have described as the continuity-of-care model that midwifery is based upon, that it would definitely impede the provision of continuity of care not to be able to provide care for clients who choose to have their babies in their hospital but also wish to have a midwife in attendance.

Mr Grandmaitre: So Bill 43 is step one in a number of steps.

The Chair: Thank you very much, and thank you for your presentation.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair: I would like to call next the Registered Nurses' Association of Ontario. We ask that you begin your presentation by introducing yourselves. You have 20 minutes, and we would ask you to leave a few minutes at the end for some questions from committee members.

Ms David: My name is Sheila David. I am a registered nurse and I am the president of the Registered Nurses' Association of Ontario. With me are Emily Phillips, also a registered nurse and the president-elect of RNAO, and Eleanor Ross, a registered nurse, a past-president of RNAO and a member of the RNAO's RHPA committee.

This morning your handout is our submission as well as the latest copy of our publication, and in that publication there is an article on nursing specialty relating to neonatal nurse practitioners.

The Registered Nurses' Association of Ontario, RNAO, welcomes this opportunity to respond to the Minister of Health's request for consultation on the Regulated Health Professions Act, RHPA. RNAO has consulted at length with the government and other organizations over the past nine years. In fact, there have been 10 submissions. In our view, the vision of this legislation has been to increase the public's knowledge of and access to health services and to foster parity among the professions. This will forward government policy and address the economic realities of the health care system.

Our positions on RHPA reflect RNAO's mandate. As a voluntary professional association for registered nurses, RNAO's goal is to lead the profession of nursing into full partnership in providing and shaping health care in Ontario. The focus of our activities is on influencing health through health policy, positioning the nurse in the workplace and building partnerships with other health care providers, the government and the public. We provide a forum for nurses at all levels and in all areas of the health care system. Our diverse membership requires that RNAO

achieve consensus and balance in defining our positions and policies.

RNAO believes that the principles of public protection and provider equality make RHPA a cornerstone of health legislation in Ontario. This legislation will affect existing and proposed legislation, as well as institutional and community structures. It is imperative that RHPA not only reflect current practice, but also provide for the evolution of health services and provider roles.

RNAO supports this legislation and commends the consultative process undertaken to bring RHPA into law and practice. However, having reviewed the legislation, RNAO believes that several proposals are not congruent with its overall intent. Indeed, they may well hamper the achievement of its full potential. These proposals may arise from historical behaviours and relationships which, while still having considerable influence, are no longer appropriate, particularly for the future during which this legislation will be effective.

The three major proposals that concern RNAO are those dealing with: first, communicating a conclusion; second, "on the order of"; and third, use of the title "nurse." These will be highlighted in today's presentation. RNAO also recommends additional changes to the omnibus section, the Nursing Act, 1991, which are included in our written submission which you have received today. We would be pleased to discuss our recommendations today as well as in the future.

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"Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction." This proposal is the first that RNAO finds incongruent with the intent of the legislation. It does not reflect parity of the professions within their respective scopes of practice. The intent of the legislation is that the public have access to sufficient, accurate information in a timely manner to enable them to choose practitioners, settings and interventions. It would seem logical that practitioners in the context of their scope of practice can communicate the findings of an assessment or a dysfunction to a client.

Although much effort has gone into developing this wording, it still reflects an attempt to limit diagnosis to five professions—chiropractors, dentists, physicians, optometrists and psychologists—even though a number of other professions also make diagnosis appropriate to their own scopes of practice. For instance, nurses make nursing diagnoses which are not to be confused with medical diagnoses. Although a significant body of literature and research confirms the existence of the value of nursing diagnoses—and we have included that in our submission—this proposal as it now stands denies the nursing profession the right to include nursing diagnosis as a controlled act.

Other professions also communicate a conclusion about dysfunction based on knowledge and their scope of practice. For example, we heard this morning from the physiotherapists.

RNAO recommends, then, that the acts recognize diagnosis or communicating a dysfunction as a controlled act for each profession within its scope of practice.

Under the Nursing Act, 1991, "on the order of a qualified person": This is another proposal which RNAO finds incongruent with the intent of the legislation and which has real potential to hamper the delivery of appropriate and timely health care. Even today, orders are written by a variety of health professions. Orders are directions regarding care and treatment of a patient. They are not directions to a health care provider. Scopes of practice determine which profession will carry out which aspect of patient care.

Currently the standards of nursing practice indicate when written orders must be on record for nurses. Therefore, this wording is unnecessary. Also, this wording perpetuates the perception that one profession is subordinate to and takes orders from another.

In addition, it is essential that this legislation allow for the continuing evolution of practice. This wording may well inhibit the evolution and adaptation of practice to new circumstances which will certainly arise during the life of this legislation. That is reflected in that article you received today.

RNAO therefore recommends that "on the order of a qualified person" be deleted.

On the issue of the use of the title "nurse": The third example of incongruence concerns the use of the title "nurse." The major aim of this act is public protection, involvement and choice. Clarity of title is fundamental to public understanding of who is who and who does what. All practitioners regulated under this act are registered. Therefore, "nurse" is a unique designation. It should be limited to the registered nurse and not extended to the nursing assistant. Sharing the adjective "nursing" with registered nursing assistants is appropriate, as this form makes it clear that RNAs work with nurses, both independently and interdependently, but are not nurses.

Nurses work in diverse settings and are situationally responsive to their client needs. Practice may be in a hospital, the clients' home or workplace. Nursing offers a wide range of care from health promotion to intensive or palliative care in urban, rural and isolated settings. Depending on the setting, the availability of other providers and clients' needs, registered nurses function within their knowledge and their scope of practice.

It is imperative that the public and other providers know who is a registered nurse. It is confusing for the public and other providers to allow four other categories of "nurse" in the act. Level of knowledge and accountability must be clearly indicated by title.

RNAO therefore recommends that the use of the title "nurse" be limited to registered nurses so that the public and other health practitioners are absolutely clear about who is a legally qualified nurse.

The Regulated Health Professions Act is important legislation which enshrines public protection and provider accountability. RNAO supports these intentions and looks forward to working with the public, the government and other providers to ensure that current and future health care practice is accurately reflected in the act.

Thank you for your attention to this presentation. We would be pleased to discuss our three priority issues as well as quality assurance and managing labour.

Mr J. Wilson: Thank you for your presentation. I tend to be very sympathetic to your suggestion that we delete "on the order of a qualified person." It seems to me when you put it in layman's terms it comes across as a bit of an insult and could very well restrict the independence of nurses even further than certainly this act was intended to do.

I want to ask the parliamentary assistant about the ministry's thinking behind the phrase "on the order of a qualified person," given the testimony we have heard where standing orders and protocols are often in place and the terms of practice as established by the nursing profession itself cover the situations where orders are required.

Mr Wessenger: I will let ministry staff reply to that.

Ms Bohnen: The review believed that within the health care system, for hazardous activities, there had to be clear authority for the provision of the service to the patient. That health professional who determined what treatment should be provided, where that treatment involved hazardous activities, had to be someone who was fully qualified to make the treatment decision, someone who could be accountable, and there should be one person responsible for the patient's care so in fact orders for patient care do exist. If you accept that then the issue becomes, where does the legal system mandate such orders, the review believed it should be written into the legislation which says that in this case nurses may perform these hazardous activities, but only where there is an order.

I think we have heard from the nursing groups—at least from RNAO this morning—saying it is unnecessary to incorporate that in the act because nursing standards of practice provide sufficient guidance to nurses as to when an order is necessary. That simply was not the review's opinion. The review felt it was a matter of sufficient importance to incorporate into the statute rather than leave it to nursing standards of practice, which to date have not even been incorporated in regulations.

Mr J. Wilson: We also heard from a nurse who was employed at a Toronto hospital indicating that in many wards there are not any standing orders. We have also heard stories about the retroactivity of orders and the day-to-day conduct of affairs on hospital wards.

Ms Bohnen: That is their view. I think later on today you are hearing from the Ontario Hospital Association. You may want to ask them from the hospital administration perspective how they view this issue.

Mr Cordiano: I am interested in asking you about the recommendation with respect to the use of the title "doctor." What you are suggesting here is that prepared nurses—I am assuming nurses who hold the PhD degree, is that correct?

Ms David: There are some nurses in the province, yes.

Mr Cordiano: If the use of the term or title "doctor" is extended to PhDs, you would have perhaps a name tag indicating that this person would be then referred to as "doctor of nursing," I suppose, or just simply "doctor." I am assuming that person would still be, in his or her field such as nursing, practising nursing with the title "doctor." In the public's mind, would that not create a discrepancy between, say, the person who is a PhD and then is referred

to as "doctor," and a nurse who is an RN? Would there not be a distinction made there by the public as to the level of qualification with respect to the kind of service being provided in nursing, shall we say?

Ms Ross: This piece of legislation to us is very visionary. It is looking to a different way of delivering services in the future. If you look at the term "doctor," the term "doctor" for a PhD is used by many disciplines. It is an academic term. However, traditionally within our system the physician has taken on the title "doctor." As we move forward and we have a variety of health providers—you know there are many and you are hearing from them, and all of these different groups specialize and advance and require more academic training and so on. They will achieve the doctoral level. I certainly appreciate where you are coming from with the confusion. For example, nurses now have RN, PhD, because PhD is the formal title, so those kinds of terms could be there. There is certainly no intent for nursing or any other provider to be seen as the physician. But we feel strongly that if we have achieved those levels of standing and academic positions, we should be able to have that title.

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Going back to the visionary statement, we keep going back to the hospital setting and the traditional view of someone being responsible and so on. But if you look in the future, there still will be hospitals, but a lot of the care we are going to provide is going to be in the community and will be delivered very differently. One hopes, at least in our view of the future, that the patient, the client, will be able to access a physiotherapist or a social worker, whoever, directly, and not have to go through and be referred as the traditional system has been. We are trying to look at this as visionary and recognize that some of these kinds of statements, and we have referred to this, as we move forward and shift how we are delivering care, can be hooks that really hamper the potential of this legislation.

Mr Cordiano: I am sympathetic to the notion that having achieved that level of academic standing—I am not opposed to the use of the term "PhD." I am trying to grapple, and I think this committee is, with the use of the actual phrase "doctor", and how that might create confusion in the public's mind with respect to differentiating between a variety of health care professionals. We are just trying to deal with that fundamental difference between who we designate as "doctor" and the use of that term as a restricted title.

Ms David: I think your concern is very valid. The concern we have also is the education of the public and taking them forward with this new terminology that is coming to them.

Mr Owens: A quick question to the parliamentary assistant: I requested yesterday a note or a response with respect to the issue of standing orders, where and how they are applied, and the issue of retroactivity. Are we going to see that in writing or will we have a response later on today?

Mr Wessinger: I will refer that to staff.

Ms Bohnen: I am sorry. We did not realize you wanted an answer today specifically about the retroactivity of standing orders. What we have begun to prepare is more

comprehensive information about standing orders and other ways in which authority is provided now in hospitals, nursing homes and in the community for nurses to practice. If you require a quick answer, specifically on retroactivity and standing orders, we can try and get that quickly for you.

Mr Owens: Perhaps if you can include that in the package.

Ms Bohnen: We certainly will include it but if you wanted a quick answer just on that point, we could try to have our staff get that answer, or can you wait?

Mr Owens: I think we can wait. We have waited nine years.

Mr Beer: The issue of diagnosis and assessment has come up in a number of cases. I just wonder if you could help the committee. Pardon my ignorance, but when you are making a distinction between what you referred to as a nursing diagnosis and a medical diagnosis, could you give an example of what you mean by that?

Ms Phillips: Say we have a two-month-old infant who is ill. The doctor may make a medical diagnosis of iron deficiency. By doing lab tests they find this child has an iron deficiency. The public health nurse may be working with this mother and infant and may find out that the mother has put the child on cow's milk instead of continuing with formula. So it is a knowledge deficit of the mother that has caused this child to become deficient in iron. The public health nurse may also find, with her assessment of the mother and infant, that the mother cannot afford formula because of her socioeconomic level. It may be she is a single mom, a young, inexperienced mother.

The nursing diagnosis takes in the whole picture of the mother-infant setting. It is a nursing diagnosis versus the medical diagnosis of iron deficiency for which the physician would order an iron supplement. The nurse would work with other health care providers to raise the mother's level of knowledge concerning the cause of the illness.

Mr Beer: In your view, that kind of diagnosis would be clearly understood in other jurisdictions as well, if we looked at the United States or Britain or Europe, as something people understand and recognize as a nursing diagnosis?

Ms Phillips: I think maybe the problem with understanding is that we picture "diagnosis" as a medical diagnosis, whereas in our nursing practice now we make nursing diagnoses which are distinct from medical ones.

The Chair: Thank you very much for your presentation. We appreciate your appearing this morning before the committee. I would point out, as I have on other days, that over the course of these hearings you should feel free to communicate with the committee in writing and add to your very excellent brief any information you think might be helpful for committee members.

BOARD OF DIRECTORS OF MASSEURS OF ONTARIO

The Chair: I would like to call now the Board of Directors of Masseurs of Ontario. I welcome you to the standing committee on social development. I would ask that you begin your presentation by introducing yourselves

and, if you would, leave a few minutes at the end of your presentation for questions from committee members. You have 20 minutes.

Mr Shekter: Thank you, Madam Chair. My name is Richard Shekter. I am legal counsel to the Board of Directors of Masseurs of Ontario, and I will allow the two ladies beside me to introduce themselves.

Ms Cowall: My name is Emily Cowall and I am the chairperson for the Board of Directors of Masseurs.

Ms Colborne: Margaret Colborne. I am the past president of the Ontario Massage Therapist Association.

Mr Shekter: The committee, I understand, has a copy of my correspondence of July 15 which summarizes the concerns and the position of both the board and the OMTA in connection with the proposed Bill 52, and the omnibus legislation. I do not propose to read it. I think I will just summarize our position as follows: First of all, anyone who is familiar with the Drugless Practitioners Act, and I am sure you all are, can imagine how welcome this new legislation is. The DPA is a complete disaster. It has been for years, and it makes it almost impossible to manage anything. We have been labouring under that for years and, hopefully, with this process being finalized, we will finally get an act that makes some jurisprudential sense and provides an element of fairness to the procedures that are, right now, established from 1919, and have not been amended since.

With respect to the procedural issues, we do not have any comments. We are content to leave the criticisms you have heard to the other regulated groups. We are content to stand by the positions of virtually anyone else. We do not have serious problems with them. They are so far in advance of what we have been dealing with for years that there is no point. We have a Rolls-Royce now, and if you want to make it a Rolls-Royce with a Bentley sticker, please go ahead. It is not our problem.

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Mr Grandmaitre: Can we quote you?

Mr Shekter: Sure, but under my assumed name. With respect to the issues we do have concerns about, we have two essentially. The first is the protected act definition, not surprisingly, of communication, and the absence of a protected act that deals with rendering services on the prescription of a physician or a qualified person. We will make a submission about that. We also have a submission, and it is a very practical one, dealing with the composition of council.

Those are the main areas I am going to deal with. Let me start with the composition of council. Under section 5 of the amended Bill 52, there is a requirement that we have, I think it is seven, and not more than eight members. We do not have a problem with that. But there is also a provision that we have five public members.

The reality is that we have difficulty getting public members interested in sitting on this board now. Historically it has been extremely difficult. We are not the College of Physicians and Surgeons of Ontario. We do not have a lot of snappy hearings and public things, and people, quite frankly, are simply not that interested.

Anecdotal: In October a member of the board ended her term. On October 10 we wrote to the ministry and said we needed a public member. They said, "Fine, we will get on to it." We said: "We have a hearing scheduled. It is a sexual assault hearing, a very serious case. We cannot proceed without a quorum. You have to help us out." "Fine, we hear you."

Two months later, in December, they phone us up to say, "Sorry, we cannot locate anybody." We say, "We have to have a hearing." "Sorry, we cannot do anything about it. Why do you not see if you can find somebody?" We spend a month. We find two names. Then on January 22 we give them two names. It takes six months to get the person appointed.

In the meantime, the hearing is in abeyance and the complainant is going crazy. I keep explaining to the complainant, "I am sorry, but we cannot do anything about it. We cannot have a hearing." Finally the ministry bequeaths us a public member, and we can start our hearing. By then we have to give notice because we do not know when the member is going to be ready, so we start the hearing in this office.

That is just to find one. You want us to find five. We do not mind having a maximum limit, but we really are concerned that if you do not reduce the minimum to, say, two, we are going to find ourselves in the position we were in, and have been in over the last five years. It is not our fault. We can get our members, but we cannot get public members interested, if history is any indication.

I would strongly urge that you reconsider that. We would like a maximum of five. We do not have a problem with that. It is the minimum that will probably stop us from operating at all, in the corresponding amendments to the other portions of the regulations that would require certain numbers. That is all I have to say about that.

Let me deal with protected acts. We are asking for two, or more to the point, if you are going to keep communication, we are asking for two; if you are going to eliminate that, we are asking for one. The first one—it is almost a flip side of what you just heard from the nurses—is, "the rider on the order of."

It has been our position from the beginning that if you are interested in protecting the public, it makes no sense at all to have the physician prescribe a specific therapeutic modality of massage therapy, but not protect the public from having persons who are not trained in massage therapy and who are not regulated carry out that order.

The way the act is drafted now, if there is a specific kind of therapy that is prescribed, anybody in the world can do it. How that serves to protect the public interest, I do not know. I have never had a satisfactory answer. I have had meetings with the HPLR people for the last four years and we have agreed to disagree, and I urge the committee members to consider it.

There is no reason why, as a protected act, if a physician or a dentist or a chiropractor diagnoses and prescribes something—we are not necessarily insisting that it go beyond the physicians. Frankly, we do not know why people who are not licensed ought to be permitted to do it, because they cannot, by definition. They have not been trained, and it is potluck. They may or may not be able to

deal with it. We see no public interest served by not having it. It is as simple as that.

Communication: I am sure that I am not the first, and I certainly will not be the last, to deal with this particular problem. Simply put—and I have set out to some extent in my letter what our concerns are—the way it works, it says in effect, if you flip it around, “It is an offence to communicate to the patient, or his representative, a conclusion identifying a dysfunction as the cause of symptoms.” In other words, you cannot tell a patient why he hurts.

Massage therapists are in the business of alleviating pain. That is what they do. What you would have us do is assess, because we have to figure out why the patient is there and what is causing the pain. We can do the work, but we cannot tell them why. We have the present chairman of the board and the past president of the OMTA here and they can, if you wish, in question period provide you with anecdotal information about what a patient encounter is like.

Just imagine, if you will, somebody coming in off the street. They have not seen a physician. They have a terribly sore neck and shoulder. The massage therapist does the assessment, which includes a physical examination, realizes that the entire back and upper quadrant is in spasm, and says, “Now I am going to do the following series of things.” The patient, naturally enough, says, “But why am I hurting?” “I am sorry, I cannot tell you that.” “What are you going to do?” “I am going to do this.” “Will it help?” “Sorry, I cannot tell you that.”

With all due respect to the rationale of this system that is supposedly in place, which is, as I understand it, to prevent people from making diagnoses upon which people will rely, to the exclusion of the medical practitioner or another qualified person, it makes nonsense of the notion of informed consent. It is over-broad and, if taken literally, it could cover the situation where a massage therapist, in response to a request for a medical report by a lawyer acting for a motor vehicle accident plaintiff, would be prohibited from communicating conclusions which they do every day, because it is going to be relied upon.

That is how far-reaching the language is, notwithstanding that everybody says, “It could not possibly have been construed that way.” I suggest to you that it can. In every day of practice, particularly in massage, they get letters from lawyers saying, “Listen, he has been injured and we want to know why it is hurting and what you are doing to alleviate it.” Under this, is it going to be relied upon by the personal representative or by the patient? Yes. Is it a conclusion as to identifying the dysfunction as the cause of symptoms? Yes.

It gets more practical. The law of informed consent and the whole consent, the treatment legislation, which is a major threat to this current government and which we wholeheartedly agree with, seems to us to fly in the face of the spirit of this particular prohibition. I have given some indications in my submissions as to why we say that, and anecdotal information.

Simply put, you cannot deal with the subject. A doctor, as it happens, and it happens quite frequently, sends a patient with a diagnosis and then requests a specific modality

of treatment. Part of the standards of practice require the massage therapist to reassess the patient to determine whether (a) there is an agreement with the assessment of the physician, and (b) whether the modality treatment prescribed is or is not contra-indicated, based on the assessment of the practising massage therapist. If that happens, and it happens quite frequently, they are stuck. They cannot then say, “Look, I cannot go ahead and do what your doctor wants me to.” “Why not?” “I am sorry, I cannot tell you.” This makes nonsense.

Finally, we have no problem with the scope of practice. We never did. We understand that other groups have made submissions. We do not intend to make any unless there is a response to a particular inquiry, and subject to that, the questions you may have.

Those are our submissions. In the materials we have given you there are some exam questions that are routine in every exam, going back for 50 years. They talk about the kinds of things massage therapists are trained to do and the kinds of questions they are asked to describe patient encounters. You will see that communication is sort of the heart of it all.

You will see the standards of practice. At pages 4, 7 and 10 of the standards, they talk about the requirement of communicating and having a meaningful interaction with the patient. You will see that. You will also see medical legal requests for reports, and the types of reports we respond with. You will see that if you read that literally, that is a prohibition under paragraph 26(2)1. The massage therapist is guilty of an offence.

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Mr Hope: Thank you for the presentation. The part I want to look at is the public members. You talked about having a hard time getting one, let alone five to serve. I would like to pose a question to you. Is it maybe that members of the general public do not want to participate in these groups for the simple fact that they are not heard and do not have the voice they should be having, that they are just there to rubber-stamp situations, to be the token figures of a board or a governance, or whatever? Is that maybe what the perception is? I hear what you are saying. You are looking for the government to ensure that the bodies will be there. At the same time, we are looking for those governance to make sure they have a responsibility, number one, to listen to the members of the general public who are an active part of it. It is a dual role, in order to make sure.

I have sat on a lot of volunteer boards before and I am not about to be there to rubber-stamp and I am not about to go—you said you do a lot of arguing too. I do not think a lot of us are there to argue. We are there to make progressive steps.

Mr Shekter: I can tell you that our experience has been that the primary response is simply a lack of interest, because massage therapy, to the lay public, in layman's terms, is boring. There is not much going on. It is not a high-profile job. People just are not interested. The persons we do have are extremely active. One of the last ones was the chairman of the board. I suggest to you that if you want to talk about rubber-stamping, it is more likely to happen

at the College of Physicians and Surgeons of Ontario, where there is a highly technical component to what they are doing, than in massage therapy cases where the bulk of the work in the board's or the council's perspective is dealing with matters that are applicable to laymen and experts alike. There are a lot of things in the section on propriety that are coming up, given the nature of the profession. They have as much input as anybody. That has never been a criticism.

Mr Hope: Would it not serve more as a positive approach to having more members of the general public there for the simple fact of public awareness and making sure the roles you do are more communicated to the general public?

Mr Shekter: Understand what our position is. Our position is we welcome having as many as we can get. But our concern is that you have put a minimum of four. We had trouble getting one. You may stop us from practising. I can tell you that the board intends to have as many as it can get and always have a full house. They do not have to worry about it. We are on the flip side where we want as many as we can get and we cannot get any. If it took us 10 months to get one, God help us when we need to have four. That is all I am saying. Do not reduce the maximum number. Reduce the minimum so that at least we can operate and have a quorum, statutorily authorized, because if you make us have four, given history, we may not get it. It is not our fault.

Mr Beer: I would like to come back to the question on communicating. Can you tell us, at the present time, under the existing legislation and regulations, is there any restriction on what you can do or say to a patient?

Mr Shekter: Well, the only restriction that by extension applies is a prohibition against engaging in an act that is beyond the scope of your expertise. I, as a lawyer, tell you that would probably include purporting to diagnose a cancerous lesion on a back. But there is nothing that prohibits communicating. In fact, quite the contrary: I prosecute, on behalf of the board, members who are in violation. It would be substandard practice not to appropriately communicate an opinion and assessment and a cause of dysfunction to a patient, rather than the other way around.

Mr Beer: I appreciate the point you make in your letter about the meaning of dysfunction and disorder, because I think that is something we also have been seized of, and others have mentioned this, in trying to define what those terms mean. Taking it from another angle, is the limit on your communicating partly related to a determination that the training that masseurs have does not entitle them, or does not give them the necessary expertise, in effect, to be able to diagnose conclusions? Is that part of what the problem is here, to the extent that you are aware of one?

Mr Shekter: We have been using the verbiage for the last five years in HPLR and making, to some extent, artificial distinctions between assessment and diagnosis. The example of a nursing diagnosis, in my view, is more properly an assessment than an evaluation. But casting the language aside, my people are extremely highly trained in physiology and modalities of therapy. They are in a posi-

tion to draw those conclusions and communicate them. In fact, they do them every day. If you saw their course curriculum, it is a two-year course. It is extremely rigid. It has much of the same kinds of course hours in physiology and related subjects that physicians do.

We do not belittle the ability of the members to do certain things. What we do say is that there is a line between medical and physiological dysfunction and we wish to maintain that distinction but within the scope of our practice. If we cannot communicate, we cannot practice.

Mr J. Wilson: Thank you for your presentation. The first point you make in your letter of July 15 to the committee concerns, as I understand it, current practice that patients have to be referred to a massage therapist.

Mr Shekter: No, not necessarily.

Mr J. Wilson: You can be a primary care giver?

Mr Shekter: And often are.

Mr J. Wilson: Then I am not quite sure I understand the first point here.

Mr Shekter: The first point is simply this: Where a physician—it happens primarily in the major metropolitan areas where the majority of the massage therapists are—does prescribe a modality of therapy, it seems to us nonsense to be able to have unlicensed, unregulated persons attempting to carry out something that is medically and therapeutically precise and that you require training for, and there is nothing in the act that prohibits it.

Mr J. Wilson: Have you a suggested wording or section for that?

Mr Shekter: We discussed it at length. Simply, it would be a prescribed or controlled act for persons other than regulated professions to carry out directives or prescriptions made on the order of duly qualified medical practitioners, something as simple as that. If you just say, "Well, go to a massage therapist," that is one thing, but if you say, "There is a prescription and it is signed and you need"—there are certain situations, for example, where doctors give those prescriptions to patients and it is contingent upon there being an insurance coverage for that service. To have unlicensed people do it seems to me to be nonsense and serves absolutely no public interest.

The Chair: Thank you for your presentation. We appreciate your coming before the committee today. If you have any further information for the committee, please feel free to submit it in writing.

ONTARIO CHIROPRACTIC ASSOCIATION

The Chair: I would like to call now on the Ontario Chiropractic Association. I would ask that you come forward and introduce yourselves to the committee. You have 20 minutes for your presentation. We ask, if you would, to leave a few minutes for questions from committee members. We have all received the extensive brief you have submitted for the committee. I would ask you to begin your presentation now.

Ms Koch: Good morning. My name is Roberta Koch and I am the president of the Ontario Chiropractic Association. At this time, I will introduce you to our representatives

here this morning. We have Dr Lloyd Taylor, our legislative representative to Queen's Park; Mr Peter Waite, our executive director; Mr David Chapman-Smith, our legal counsel; and, finally, Dr Robert Haig, immediate past president of the association and our current chair of the RHPA committee. Dr Haig will now make the presentation to you, followed by David Chapman-Smith. Then we will be prepared to answer any questions you might have of us.

Dr Haig: While there are many aspects of the RHPA that the Ontario Chiropractic Association would like to applaud, the amount of time we have before you today simply does not permit us to dwell on the many positive and progressive aspects of the legislation. Suffice it to say, as you have heard from others, this legislation stands as one of the most comprehensive and progressive pieces of legislation in the world. Congratulations are due to all those involved in its development.

Today, we want and need to focus the committee's attention on the very important concerns our profession has regarding the proposed scope of practice for chiropractic that is in Bill 46.

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The members of the committee may already be aware that while most of the professional groups involved in the review gave their written sign-off, their agreement on their scopes of practice, the OCA did not. The OCA did not sign off because the proposed scope of practice developed by the review team, and agreed to by the Ontario Medical Association but not by us, reduces the existing scope of practice of chiropractors and reduces the availability of services to the public. It does this by removing the existing right and the existing duty of chiropractors to diagnose disorders of extremity joints: elbows, knees, shoulders. More important, it does this without any justifiable cause whatsoever.

The HPLR process served as a very successful vehicle for many groups in ironing out their differences over the past nine years. I regret to tell you that in our situation the differences are not resolved. We are counting on the members of this committee and each of the three political parties to look very closely at this issue and to resolve the differences during the clause-by-clause review of the legislation. As far as chiropractors are concerned, the outcome of your deliberations on this point will have a major impact on the place and value of chiropractic care within the health care system of Ontario in the future.

I think it is fair to say that most members of this committee are aware of some of the history of the struggle that our profession has had in gaining regulated acceptance in this province and in a number of other jurisdictions around the world. Today, of course, chiropractors are well accepted by the public. Indeed, we are the third-largest primary health care profession after physicians and dentists.

We have grown not because we have been accepted by the more traditional elements within the health care system, but rather because our treatment modalities have proven to have effective outcomes. We have grown because consumers vote with their feet. Most of our patients

are referred to us by other patients whom we have treated successfully.

Over the years, because of the increasing level of public acceptance and because of the growing body of scientific evidence that supports the efficacy of chiropractic, government has tended to recognize that level of consumer acceptance. Indeed, when developing the public health insurance system in Ontario, the legislators, in response to public demand, included chiropractic services among those paid for under the Ontario health insurance plan. More recently, the Ontario motorist protection plan enhanced access to, and freedom to choose, chiropractic care. So we have gained acceptance and we have progressed.

However, in the legislation that is before you now you will see that in our profession's case the HPLR process has actually been used to reduce the traditional scope of practice of chiropractic. We did not enter into this process with any intent to increase our scope of practice, but we cannot accept a net reduction in the scope that this proposed legislation includes.

It is important that the members of the committee understand that it was a fundamental principle of the HPLR process that no existing scope would be reduced unless there was convincing evidence of lack of qualification and harm to the public. During the course of the nine years of this review, no one at any time produced any evidence of that sort, anything that could be used to justify the removal of diagnosis of non-spinal joints.

Current legislation, education and training all include the ability of chiropractors to treat all joints of the body. You heard yesterday from the chiropractic college, which explained in some detail the education in that regard. The proposed scope in the legislation you have before you does not provide for the diagnosis of non-spinal joints. We are appealing to the common sense of the legislators on this.

Just think about it. The diagnosis of disorders of spinal joints is at least as complex and as complicated as the diagnosis of non-spinal joints, and it is quite illogical to have one without the other, but for some reason that has not been revealed to us, the OMA has opposed the inclusion of diagnosing extremity joints within our scope of practice.

The removal of this important part of practice affects the public in two ways. First, it reduces their level of protection. Currently a chiropractor has a legal duty to provide a full diagnosis. Under the proposed law, the chiropractor has a lesser duty than that. Second, it limits the freedom of choice, and that goes against the whole intent of this legislation.

I am going to ask Mr Chapman-Smith now to give a case example that will illustrate for you the effect that the legislation, as proposed, would have in Ontario.

Mr Chapman-Smith: I will present a case example which illustrates this and then refer to the current state of the law, because that is obviously crucial. I have been here during hearings when it has been suggested that the law may not be as we have stated and I want to get that clear before you today.

But first, to look at the case, you will see in the submission attached as appendix C—the appendices are in green at the back of the submission; at least in most of them, I think. Some of them may be white, but you will

see at the back there appendix C, and it is to that statement I now refer. That is a statement by Paul Peschisolido, who is with us today sitting in the front row. I would have asked Paul to come forward and read this statement if there was more leisure and more time, but I am going to whistle through it a little bit more quickly, ask him to confirm its accuracy, and he will be available for questions. As we read this, I invite you to consider that what he describes here is the health care system as you would like to see it in Ontario with the degree of co-operation, flexibility and freedom of choice such as is the intent of this legislation.

Paul states that he plays in the centre forward position of the Toronto Blizzard Soccer Club and the Canadian National Soccer Team, and he has played for Canada since the age of 15 on those various teams listed there and now the national team.

"I have had a number of leg injuries during my career, and am available today because I am still recovering.... Leg injuries are frequent in soccer. I wish to explain briefly how the Toronto Blizzard sports medicine team works, with particular reference to the role of Dr Robert Gringmuth, a chiropractor, in the diagnosis and management of injuries.

"For the three years I have been with Toronto Blizzard the sports medicine team has been led by Dr Gringmuth. He works in close association with our consultant orthopaedic surgeon, Dr Geoff Lloyd...other medical consultants such as Dr Tom Fried, and team therapists and trainers.

"When someone is injured in play in Toronto the standard arrangement is that he is given temporary assistance at the field...then sees Dr Gringmuth for a full diagnostic workup and treatment.

"During early 1990, for example, I sustained a quite bad right knee sprain. I saw Dr Gringmuth at his office and he examined me and took X-rays to rule out bone fracture. He diagnosed the problem as a right medial collateral ligament sprain in the knee. He treated me with ice, interferential therapy and mobilization, and then directed my rehab program.

"Sometimes a player will be taken directly to Dr Lloyd at the Toronto Western. This would be in cases, for example, where initial assessment at the field is that a cast will probably be necessary"—and obviously chiropractors do not do that.

"My current injury falls into this category. I sustained a severe left ankle sprain.... My ankle was X-rayed"—at the hospital and there was a cast immediately arranged—"and from there I was referred to Dr Gringmuth," who is the team doctor and the chiropractor. "He then saw the X-rays and explained I had a third-degree sprain without bone fracture. My ankle was in the cast for about three weeks, and for continued daily rehab Dr Gringmuth has referred me to physiotherapy at the Durham Orthopaedic Clinic which is near my home in Pickering.

"I am told that the proposed new law might not provide for the detailed diagnosis and management of injuries such as mine by a chiropractor. The experience for me and my teammates, and obviously the Toronto Blizzard management, is that Dr Gringmuth has as much understanding

about these injuries as anyone and runs a first-class sports medicine team."

Just for the record, Paul, I will ask you to confirm that is accurate?

Mr Peschisolido: Yes.

Mr Chapman-Smith: Thank you. This is what happens under the present law. We can look first at the freedom of choice that Paul himself has, but I want to focus for a moment, because this goes to the heart of it, at the Toronto Blizzard Soccer Club and its management. At the moment, chiropractors are authorized under the law to diagnose these problems. They have a choice. They could have heading their team a physician or a chiropractor. They have found a chiropractor with whom they are happy, who is doing an excellent job for them and he runs that team.

There is no question that under the law as proposed they could not do that. They could not have expensive, professional stars at risk of injury and have their whole team run by someone where it is clear under the law that he is not authorized to diagnose those problems. I think that is apparent to everyone.

From that, then, I want to turn to what the current law is and deal with this very briefly, again because of time. If you go back to appendix B you will see a summary of the current law on appendix B-1, and then attached to it the actual provisions of the legislation.

It has been suggested in a briefing document you have been given that chiropractors are not currently authorized under the law to diagnose extremity problems. That, in my humble submission, is completely wrong. What the Ontario Chiropractic Association proposes is that if there is any doubt whatsoever on that issue, an independent legal opinion be obtained from any senior lawyer in Ontario. We would nominate a lawyer, the ministry could, and they could nominate an independent person to give an opinion on whether chiropractors under the current law are entitled to diagnose.

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The summary of the present law is there. The Drugless Practitioners Act itself does not have a scope of practice. It is very old legislation; 1920s. There has been case law since. It is a system of treatment. The body of the legislation and the case law makes it absolutely clear that chiropractors have this right under the current law. At the bottom of appendix B-1 is a summary of the current position. This is a legal opinion obtained from Blake, Cassels and Graydon in 1988. The two lawyers involved there were John Brownlie, a respected senior lawyer, and also John Ronson who we involved because he was executive assistant to Mr Elston when he was Minister of Health and was intimately familiar with these issues. You will see what they have to say and how they say the public will be ill served if this goes.

Why is there a problem then? Why is this not in the scope? The OCA says quite clearly it is in the scope because organized medicine has opposed it, but without ever being prepared to put the grounds for its opposition in writing or present a case. In the nine years of the HPLR we have never been given anything overtly, in the open, to

argue this case. In a briefing document you have, which is attached as appendix E, and the precise page is E-11, physicians argue chiropractors are not qualified. How I wish, with respect, I could have a day to cross-examine any of these physicians on the stand so you could get at the truth. Many physicians, including the ones that work with Dr Gringmuth, obviously disagree. But here you have the heart of the problem and because of time I will not be able to take it further than that.

I merely conclude by saying that we have emphasized today one of the various important issues. The other issues appear in the executive summary and in the text of the brief. I know Mr Beer was asking questions some days ago about a harm clause and about the balance of diagnosis and assessment. We have what we think are constructive and helpful suggestions in that area, but obviously there is not time to get into all that today.

If you look at appendix A you have there, both as to scope of practice and as to authorized acts, exactly what is in the proposed law and exactly what the proposed amendments from this association are. It is submitted that those are conservative, uncontroversial and we look for your support in those.

The Chair: Thank you very much for your presentation. For the information of the committee, I have had a request for Mr Wessinger to ask a question. I will place him first on the questioners' list and then continue with the line of questioning.

Mr Wessinger: I am just wondering if you could provide us with a copy of the opinion from Blake, Cassels and Graydon on this matter.

Mr Chapman-Smith: Certainly. I have one today I will leave with you.

Mr Wessinger: I would like a copy of that. Thank you.

Mr Jackson: Yesterday, as you indicated, we heard from the college, and I made several statements then with my own experience as it relates to this issue of diagnosis of joints other than those that emanate from the spine. I wonder if you could share with this committee what you feel the differences are, because my case story is similar to our guest's, and perhaps you as professionals could indicate the difference, if any, and why perhaps the government is moving in this direction.

Dr Haig: That is the point I made in my opening comments, that there really is not a difference and that is why we find it illogical that one should be omitted.

Mr Jackson: Does this not have serious implications for the Workers' Compensation Board as well? I have cases of lifting problems associated with the shoulder, the elbow and the wrist. My injury was a baseball injury, but it is quite a common industrial accident in terms of its manifestation. Yet it occurred to me last night, as I was thinking about this, that this also includes several of my constituents who have come to me with this kind of injury. Being right-handed, I was okay, but the physician had me so bound up I could not do a damned thing and I was having problems with my whole side of my body as a result of a wrist injury until my chiropractor relieved me in one afternoon of all the pain.

Dr Haig: The short answer is yes, and that is because, as you know from your constituents, there are a lot of people who have difficulty with the compensation board, and I can assure you that chiropractic patients who have extremity problems have difficulty with the compensation board as well. I would expect that were the legislation to be passed the way it is now, those patients would have increasing difficulty.

Mr Jackson: As a question to the ministry, would it be possible to investigate if the ministry has even looked at the concept of the implications this might have on the WCB and WCB costs? My limited understanding is that the cost would be more extensive. The kinds of therapies and the regular physical checkups that are required from a physician would be more expensive than access to the chiropractors at their rates. Could that be looked into, if in fact the government consulted with this area, in terms of the implications to taxpayers in Ontario, let alone to patients who need this service?

Mr Wessinger: I will refer that to ministry staff.

Ms Bohnen: Remember, please, that the restriction here is not in terms of assessment or treatment of articulation by chiropractors. The issue is confined to statutory authority to diagnose disorders and dysfunctions of these articulations. I think I would then rephrase your question as, will this statutory provision or lack of provision in the Chiropractic Act affect current WCB policy? I do not believe it will, but I would like to take the opportunity to have our staff contact the WCB and get back to you on that.

Dr Haig: Might I suggest that it will have an influence anywhere that there is a third-party payor where there is medical influence, because injured patients, compensation patients, motor vehicle accident patients will be told, "For that injury, you need to see a physician." That is exactly what will happen.

Ms Koch: In fact, I have been actually told by WCB administration that they are watching this very carefully to see that we do have the ability when this legislation is passed to diagnose non-spinal articulations. They are aware of what is happening.

Mr Owens: My question is to the parliamentary assistant. Can you give any kind of rationale why the non-spinal joint diagnosis clause was not included in the controlled acts? I do not understand that they can do just about everything else, receiving training in things like ophthalmology and psychiatry and otolaryngology, but something that is completely germane to their practice would not be included. I do not understand that.

Mr Wessinger: I will refer that to staff.

Ms Bohnen: Fundamentally the review believed that the appropriate scope of practice of chiropractors was in relation to disorders and dysfunctions of the spine and joints, the condition of which related to the spine. I think what we are hearing is a very strongly felt view from the chiropractic profession that their expertise and education qualifies them to diagnose in relation to problems of articulation unrelated to the spine.

I think the issue before the government and the Legislature is whether the legislation should recognize that expanded scope of practice. I am not arguing whether it is expanded vis-à-vis the current law or not; I am just saying the review thought, "Restrict chiropractors' diagnostic authority to the spine and related articulation." They want this legislation amended to authorize them to go beyond that, and that is the issue you have to decide. All I can tell you is that the review thought they were specialists in the diagnosis and treatment of spinal disorders and dysfunctions and that this is where the law should stop.

Mr Jackson: On a point of information, Madam Chair: I am sorry, but the counsel is suggesting that they are looking for an expansion. Are you trying to imply that what my chiropractor did for me was illegal?

Ms Bohnen: No, I am just saying—

Mr Jackson: I just want to make that clear. I understand we are taking away that aspect of it in this legislation and I want to make sure that the record is clear for all members of the committee, including counsel, that this bill represents a restriction in this activity. It does not represent an expansion. I want to make sure we are clear on the language here.

The Chair: It is clear, Mr Jackson, that there seems to be some disagreement on the point you just made. I will ask for final clarification from Mr Wessinger.

Mr Wessinger: It is certainly the opinion of the government that there is no restriction with this existing legislation. In fact, this existing legislation is an expansion—

Mr Jackson: No, that is the Toronto Blizzard.

Mr Beer: Madam Chair, I believe you are going to provide a copy of the Blake, Cassels opinion to the staff. Assuming it is not 500 pages long, could each caucus get a copy?

The Chair: What I would request is that the association give the opinion to the clerk and she will see that all members of the committee receive it. I have one request from Mr Wessinger.

Mr Wessinger: Yes, I would like to have some clarification from counsel.

Ms Bohnen: I think I should have an opportunity to say to Mr Jackson that what I said was that the review recommended restricting chiropractors to diagnosis in relation to spine and spinal articulation. You are hearing a request for an expansion not relative to the existing law—I do not wish to debate that this morning—but an expansion relative to what the review recommended.

The Chair: Is that clear for everyone? Mr Hope, you had a request for information.

Mr Hope: Yes, and I am not sure if I will get all this exactly the way it should be, but during the days that the ministry is here, there seems to be a concern, and I guess where the concern lies is with the general public and those people who are victims of work accidents. I feel it would be most appropriate, during a time allocation, if possible, to talk with the board about this whole—

The Chair: You are referring to the Workers' Compensation Board?

Mr Hope: Yes.

The Chair: That is on the dates of September 16 or 17.

Mr Hope: Yes, within that time frame.

The Chair: Your request is duly noted. Mr Wilson, you have another request?

Mr J. Wilson: Yes, a request for information. Perhaps counsel could provide us with the evidence or the reasoning behind the review committee's decision to limit, as we are hearing from testimony today, the scope of practice to diagnose functions.

The Chair: You will have an opportunity to discuss it with Mr Schwartz directly on September 16.

Mr J. Wilson: I am sure there must have been documentation provided to the review committee, and perhaps we could come to our own conclusions, since we are being asked to settle this at this committee.

The Chair: For your information, again I would just state that Mr Schwartz himself will be here on September 16.

Mr J. Wilson: Prior to his arrival I would like to have the opportunity to review how this decision came about, if that is possible.

The Chair: I will just leave that on the record.

I want to thank you for your presentation.

Ms Koch: Thank you, Madam Chair. If I could just take one moment, we realize that time is very tight and we thank you for the opportunity to be able to address some of our very important concerns with you. I want to just note that we have a number of other equally important concerns and we would be happy to discuss them with you any time, anywhere.

The Chair: I would suggest that if you have any additional information during the course of these hearings, you feel free to communicate in writing through the clerk or any member of the committee at any time.

The committee recessed at 1204.

AFTERNOON SITTING

The committee resumed at 1400.

ONTARIO HOSPITAL ASSOCIATION

The Chair: The standing committee on social development is now in session. I would like to call on the Ontario Hospital Association and ask that you come forward. You have 20 minutes for your presentation. I would ask that you begin by introducing yourselves, and also, if you would, leave a few minutes at the end of your presentation for questions from committee members. I would ask that you begin your presentation now, please.

Mr Birkness: Thank you for allowing us to make a presentation to you this afternoon. My name is Brian Birkness. I am the chairman of the board of the Ontario Hospital Association. With me is our senior legal counsel, Carolyn Shushelski, who will help me with this presentation. Also with us are Gordon Cunningham, the president of the Ontario Hospital Association, and some of our staff members.

We at the Ontario Hospital Association are pleased today to have the opportunity to share with you our observations and recommendations regarding this legislation, which charts new directions in the field of health. Our association is supportive of the Ministry of Health's and the Legislature's efforts to define and reform the regulatory framework for health care professionals in Ontario. Members of this committee will be aware of our keen interest in the development of this legislation through three governments and nine submissions on the part of OHA since 1982. Committee members have copies of our submission, including an executive summary, and our recommendations regarding the Regulated Health Professions Act and the health professions acts.

This legislation is of vital importance to us not only because of how it impacts on the role of health care professionals but also because of its potential influence on how hospitals will operate in the future. As you personally have observed in the past, this type of legislation will have a ripple effect on other legislative initiatives such as the Public Hospitals Act review. This review is critical to the functioning of health professionals in the hospital. Issues under consideration include who can write orders for treatment and diagnostic procedures, who can admit patients and register outpatients, and which professions will have the right to apply for hospital appointments and privileges.

Another area of concern to us in the proposed new legislation is imposing personal liability on directors of corporations. This will profoundly affect the willingness of directors to serve on hospital boards. OHA cannot support such a provision.

Like many of the organizations involved in health care in Ontario, the OHA believes the safety net clause, the former section 27.04, would, if reintroduced, have far-reaching implications not only for the health care community but for society as a whole. In our view, the potentially negative impact of such a provision would outweigh any existing need for the section. We submitted our comments on this matter several months ago to the Minister of

Health. You will find a copy of the letter in appendix A of our submission. We are heartened to see that the Minister of Health agrees with our position and has not included a section similar to 27.04 in the proposed legislation.

Our observations on the legislation and other matters are outlined more fully in our brief, but for the purpose of our discussion today we would like to concentrate on three major areas of concern: delegation of controlled acts, diagnosis and privileges.

Carol Shushelski, the Ontario Hospital Association's senior legal counsel, has made a thorough study of the proposed legislation and will summarize OHA's concerns and observations for the committee.

Ms Shushelski: Members of the committee will understand that we have a special interest in that section of Bill 43 which deals with the delegation of controlled acts. First of all, we are pleased that nothing in this proposed legislation will change the current situation, which permits the board of a hospital to decide which acts, from those permitted to be delegated, will be delegated by one health care professional to another health care professional within that hospital.

We are, however, concerned over how controlled acts are approved for delegation. Requiring the passage of a regulation for the delegation of each act would result in unwarranted delays. Due to the shortage of physicians, in many instances nurses and other health care professionals perform acts in the practice of medicine to ensure the delivery of quality care. This is made possible through the delegation process. It is crucial that determining which acts may be delegated be as simple and responsive as possible. In our view, the delegation of acts should not be the subject of regulation. Instead, it is our recommendation that the established and existing practice of co-operation among the colleges, the Ontario Medical Association and the Ontario Hospital Association continue to be the mechanism by which delegation of controlled acts by or to members of a health care profession is determined.

The proposed legislation must also be amended to accommodate existing realities. One of the problems facing remote areas of Ontario, especially the north, is the shortage of physicians not only to perform the medical acts themselves, but even to delegate them. As part of the delegation process, physicians must teach the act to nurses and other health care professionals, train them, and examine, certify and recertify them on a regular basis. For example, some acts within the practice of medicine are performed by nurses, acts traditionally within the jurisdiction of physicians and requiring a high level of training and skill. Their services are particularly invaluable in those aforementioned areas where the shortage of physicians is acute. We draw this to your attention as consideration should be given to how the new legislation will recognize the role some nurses play in the north.

On that point, I would like to make one comment with respect to the recent addition of authorized acts for nurses. We note that nurses may now perform a "prescribed procedure below the dermis or a mucous membrane on the order

of a qualified person." We recognize that this is one way of going beyond the process of delegation; however, I think more consideration needs to be given as to how this would be implemented.

We have serious reservations regarding the diagnosis clause as it is proposed in the Regulated Health Professions Act. Communication by any health care professional to patients is critical to the delivery of high quality health care. Specifically, we are concerned that subsection 26(2) of the act as it is now worded could seriously inhibit communication between health care professionals and their patients.

The section states in part, "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion." We strongly oppose the linking of communication with diagnosis. Communicating with a patient is at the very foundation of effective health care delivery. If the provision remains linked to the diagnosis, health care professionals who do not have the authority to diagnose as an authorized act of their profession may avoid discussion with patients. This includes nurses, physiotherapists, respiratory therapists, pharmacists, chaplains, social workers and others. Fear of violation of the act will cause health care professionals who cannot diagnose to avoid discussing with the patient his or her disease, disorder or dysfunction. As it stands, the utterance of the diagnosis by a person other than the physician or other health care professional authorized to diagnose would be an offence under the act.

With respect to the act of diagnosing, we recommend that the focus be related to the process of diagnosing and not to the utterance of the words. We therefore recommend that the section focus on making a conclusion or identifying a disease rather than on communication to the patient or his or her representative. We are heartened that the minister recognizes the problem and is looking for advice from the committee on wording that will make it possible for practitioners to communicate as fully as is desirable with patients.

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Finally, I wish to speak about the legislation's impact on self-employed health care professionals seeking access to hospitals. Existing legislation under the Public Hospitals Act and regulations provides that only physicians and dentists can apply for an appointment to either the medical or dental staff of a hospital. It is also a requirement under existing legislation that all inpatients be admitted on the order of a physician and that all outpatients be registered under the authority of a physician on the medical staff of a hospital. Legislation requires that orders for treatment or diagnostic procedures in a hospital be in writing by the physician or dentist giving the order. Physicians are therefore very much the gatekeepers to hospital care.

There is now a strong body of opinion, both inside and outside the hospital field, that changes should be made to provide other self-employed professions with the opportunity to practise within hospitals. Some of the newly self-governing professions believe they should be able to practise in the hospital setting without necessarily referring

patients to or receiving referrals from a physician. Some professional groups, including midwives, have indicated an interest in seeking privileges to practise within hospitals. Some professional groups wish to have access to outpatient care facilities of hospitals and wish to be allowed to write orders for treatment or diagnostic procedures without physician involvement.

On the other side of the issue is the consideration of whether every patient and outpatient should have a physician overseeing his or her care. The outpatient issue is difficult. On one hand, a more flexible approach to access by various health professions to the outpatient clinics and departments should be considered. However, professionals who are not employees go through a stringent appointment process in order to determine what privileges, if any, they may be permitted at the hospital. This includes privileges in respect of admission to hospital and access to and use of outpatient facilities.

Should such a process of credentialling and delineating privileges continue just for dentists or physicians? Should the process be expanded to include other health professions? Should the whole system be relaxed to permit any health professional access to and use of the hospital facilities by virtue of the professional holding himself or herself out as a particular professional?

Any change in existing practices in the hospital setting in respect of patients and outpatients must be given careful consideration in order that all aspects of these issues and questions be fully examined. In that respect, the OHA wishes to make the following points:

The authority to determine who within a profession may be granted an appointment and privileges at a hospital and who may have access to register outpatients should remain with the hospital board.

A hospital board must maintain the right to grant or reject, through its established process, application for appointment and reappointment according to its needs. It must also determine the extent of the privileges within the defined scope of practice of each health professional.

Decisions on whether midwifery service or any other service should be provided in a particular hospital, and how it should be provided, should be made by individual hospital boards based on local considerations.

Within the defined scope of practice of midwifery or any other health profession, each hospital should have the right to establish its own policies, protocols and procedures with respect to the provision of that particular service.

That concludes my presentation on behalf of the Ontario Hospital Association. I will now turn back to Brian for concluding remarks.

Mr Birkness: Members will note that besides the oral presentation, our brief contains a number of recommendations and observations in such important areas as regulation of health care providers, registrars' powers of investigation, quality assurance committee, orders for treatment and diagnostic test.

Members of the Ontario Hospital Association are very aware of our responsibilities to the people of this province in providing the best possible health care. We are also aware that the watchword is teamwork, that everyone

charged with the responsibility for health care must work in partnership in order to meet the challenges ahead. We want to assure the members of our continued co-operation. Now we would be happy to answer any questions.

The Chair: Thank you very much for your presentation. All members of the committee have received the full presentation as well as the verbal presentation. I have a question; Mr Beer.

Mr Beer: Thank you for your submission. I know you said with respect to the safety net clause that it is outlined in appendix A of your submission, but I wonder if just for the record, because this is an issue that has come up and I know will come up again, you could summarize the reason you think it is better that clause not be there.

Ms Shushelski: We considered this very carefully at the OHA because we understand that the intention with respect to that clause is to protect the public. We also noted in reviewing the remarks in the original review from 1989 that it was intended that the protection of the public was to be attempted to the extent possible, and we tried to keep that in mind. One of the concerns that we had was that it would in some way inhibit persons who were not regulated professionals from providing care or treatment or advice to friends, family, good Samaritan acts.

Now, we do recognize that the controlled acts have been very well set out, and that there are exceptions and exemptions whereby you can treat someone in an emergency, members of the household. But our concern is that with respect to former section 27.04, it was much broader than the legislation itself was focusing on, and we were not comfortable. We did not feel assured from the way it was worded that it would not inhibit persons from coming forward to help others; a mother, for example, applying a Band-Aid, perhaps a hot-water bottle, things that it may never have been the intention of the legislation to inhibit. A volunteer, someone in the community, who wanted to help someone, care for them and advise them—would they feel somehow inhibited, would they feel stifled? We felt that if that clause were to be introduced, and in our brief, we make the point in some detail, there would have to be recognition that individuals in the community would care, treat, advise, and the degree to which persons would be able to do that would have to be identified for those particular categories of individuals.

Mr Owens: One of the issues that has been flagged in front of the committee, especially by nursing groups and nurses themselves, is the issue around standing orders. As an employer representative, have you ever been in a situation to advise an employer when a physician has refused to sign retroactively a standing order where a nurse has taken action to perform a procedure? What advice would you give an employer in that situation?

Ms Shushelski: The first question, have I ever been asked? I am not aware of a physician ever refusing to sign an order for which he set up originally. What happens with standing orders is—and you are probably aware—that the hospital, as well as the physician, all the parties involved, are very clear about what will be a standing order.

What I advise is whenever you have a standing order, and this is the advice I give, even before you go ahead with the standing orders—you know what they are; they are written in front of you—is that a confirmation is necessary over the telephone, whatever, if possible with the physician so that you are confirming it, and then he or she signs the order upon arrival at the hospital thereafter.

As far as a physician refusing to sign an order for which he has already set up, I have just never experienced that happening. But certainly, if the nurse did not follow the standing order as it is set out, then I think the physician has a right to question why he should sign an order that someone has not followed appropriately.

Mr Owens: There seemed to be an issue around the physician second-guessing the nurse in terms of whether the procedure was, at the time, warranted. In the nurse's judgement, it was, and the physician apparently felt that it was not. So this is the issue that has been flagged in front of the committee.

Ms Shushelski: My understanding of a standing order is that these are already written out very clearly as to what happens in this particular situation. I am not clear as to how the physician would be second-guessing the situation. If the patient is arriving and is going to the operating room for an appendectomy the next day, it is quite clear what has to happen. The orders are generally set up that you do certain blood work, urinalysis. It is quite clear.

Mr Owens: Maybe in terms of saving the committee time we should get together with the Ontario Nurses' Association and talk about some of the issues they have had with respect to problems without standing orders.

The Chair: I have mentioned to other groups and organizations such as yourself who have brought forward excellent presentations that if there is any additional information based on some of the questions—I know you will be monitoring the proceedings through Hansard—if at any time you feel there is information that the committee should have which would be helpful, please feel free to communicate with us in writing through the clerk.

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REAL WOMEN OF CANADA

The Chair: I would like to call now on REAL Women of Canada. Please come forward. I would ask that you begin your presentation by introducing yourselves and ask if you would leave a few minutes at the end of your presentation for questions from committee members.

Ms McNamara: My name is Lorraine McNamara. I am a legal secretary and a mother of six. Mary Fay here wears a lot of hats, but she is a registered nurse. I am not sure if you have a family too, Mary.

Ms Fay: No, I am not married.

Ms McNamara: Not married? Well, Mary and I are REAL Women, but we have just met for the first time this minute. As evidenced by our presentation to the Task Force on the Implementation of Midwifery in Ontario in October 1986, and I have attached a copy to this presentation, REAL Women of Canada has serious concerns with

respect to the training, responsibilities and rights of midwives in Ontario.

We have no quarrel with the intent that midwifery be given professional status. The occupation of midwifery is respected worldwide. We welcome the establishment of an official College of Midwifery. However, recent tragic events in which apparently unqualified midwives acted in both BC and Ontario resulted in the death of babies. That does point up very strongly the need for some kind of control.

However, the College of Midwifery, which is to be a regulatory body coming into existence under Bill 56 at the same time as passage of Bill 43, we understand, is to be self-regulating. The final decision has not yet been made with respect to prerequisites for membership in the college, although apparently the Interim Regulating Council on Midwifery has decided that a nursing diploma will not be necessary. It is expected that some form of post-secondary school education, possibly university-level, will be required and entry may be direct into the college. There is at this point no midwifery training program in existence. This has not been decided yet.

The objection of REAL Women to the passage of Bill 43 with respect to midwifery is simply that there is no track record on which to base the right of self-regulation for the proposed College of Midwifery. By track record we mean there is not a sufficient history of midwifery in Canada to provide the necessary knowledge and hands-on experience to justify setting up a college independent of the established medical professions.

REAL Women believe in the future of midwifery in Ontario. For example our national president, Judy Anderson, told me she was delighted to have the assistance of a midwife before her last baby, and the midwife was at the hospital with her for the birth and gave a lot of helpful assistance following the birth.

I was not going to mention this, but I might tell a little anecdote which is personal. My last baby, number six, was born in hospital, and while I was waiting in the labour room the nurses approached and they said: "You seem a fairly relaxed mother. Would you let us test this new monitoring equipment we have? The salesman is here and he's trying to show us how it works." So they had me belted up and they had the machinery there and all the little blips going and the poor salesman was having a dreadful time demonstrating. Finally one of the nurses looked at me and she just looked at my face and finally she said, "Whoops, the baby's here," and that was it, out of the room for everybody, the baby was here. She was a nurse-midwife. She delivered the baby. It was the nicest delivery I have ever had. She was super. So my personal experience with midwives is very, very positive.

A review of the other professions which would be granted self-regulatory powers under Bill 43 indicates that most of them have long-established colleges or associations which have over the years developed strict accreditation requirements. For example, a dietitian must complete a four-year bachelor of science program and serve a one-year internship; a physiotherapist must complete a bachelor of science program plus further qualifying training; a

chiropractor must obtain a bachelor of science degree with high standing plus three years at chiropractic college and a one-year internship.

It has not yet been decided exactly what prerequisites would be required for midwifery except that, unlike the British system, a nursing diploma will not be required. I would mention here too that midwives will be authorized to perform and repair episiotomies, give injections and employ invasive procedures. All of these are medical procedures. We pose a question: Had professions such as chiropractic or dietetic requested self-regulatory powers before their associations had established credible records, would these powers have been granted? Probably not, yet neither chiropractors nor dietitians are likely to encounter the sudden life-and-death situations which inevitably will be faced by some midwives.

It is understandable that no profession would willingly suffer negative publicity or even the possibility of a lawsuit, which could happen if one of their members is found to be incompetent. There is a strong temptation for these people to cover up situations like that, and just recently the doctors have been seriously criticized because they were not dealing with complaints about sexual abuse of patients. It has been felt that they were not dealing with it properly.

A recent task force headed by lawyer Mary Lou McPhedran made several startling recommendations, one of them that the complaints and discipline committee of the College of Physicians and Surgeons be loaded with members of the public. That would result, in certain instances, in the college being put under the control of non-medical people and that would mean they were not self-regulatory in that instance. If the right of self-regulation by a highly respected profession in matters dealing with sexual abuse of patients can be challenged, surely this committee should question the self-regulation of a not-yet-established college, some of whose members may very well face life-and-death situations.

The proposed College of Midwives would indeed be self-regulating. The council is to be composed of up to 10 elected midwifery college members and up to only five government appointees. This council will in turn appoint members to the following committees—I will not go through the makeup of them—executive, registration, complaints, discipline, fitness to practise and quality assurance. In all of these, if you have noticed from our presentation here, the ratio is very much in favour of the college members, so they would be self-regulatory.

It should be noted that nowhere in Bill 56 is it indicated that medical backgrounds would be required for council members. Especially with respect to the council members who are to be appointed by the government, it leaves the door open for the appointment of political activists who may not be at all competent in medical matters.

In Canadian law today, while the mother is protected against bodily harm, there is no protection for the unborn child. Until a baby is free of the birth canal and breathing, he or she has no status as a person under Canada's criminal law. The recent Sullivan and Lemay case, in which two midwives were found to have been at fault in the death of a baby whose head was free of the birth canal but who was

not yet breathing is a frightening example of this fact. This situation is not unique. There was a similar tragedy recently in Ontario.

Because there is no law protecting the life of an unborn child, this Legislature must make every effort to ensure the safety of its littlest citizens. It follows therefore that the profession of midwifery must be competently controlled and scrutinized.

REAL Women of Canada respect the profession of midwifery and agree that a College of Midwifery should be instituted in the province of Ontario. However, since there is no existing midwifery organization in Ontario which has proved over the years that its members are well trained and competent, we do not believe the proposed College of Midwifery should become self-regulating upon its inception. We suggest instead that until such time as graduates of the College of Midwifery have been in practice long enough to assess their capability as midwives, supervision of the college should be placed with experienced medical organizations such as the Ontario Nurses' Association or the College of Physicians and Surgeons of Ontario.

1430

The Chair: Thank you very much for your presentation.

Mr J. Wilson: I too want to thank you. What do we do with the midwives who are currently practising, though?

Ms McNamara: There were probably recommendations made by the interim committee that has been studying it. If one of the recommendations was that they would, say, have to have a university degree, that might be a problem right there. I do not know how they were solving it. I would say that they would need training. Again, I would like to see the training come under the medical establishment.

In Ontario there is really no excuse for not getting at least a nursing degree if you are going into midwifery. Nobody is denied an education here. It is not like many parts of the world where this is the only thing available. If a person cannot handle a basic nursing degree, the first level, then I would question the competency of the midwife. I do not think, by the passage of this act, that it is going to make it illegal. Is it? That I do not know, but the same problem would arise even with the establishment as it is set up here. A lot of those who are practising probably would not qualify.

Mr J. Wilson: Perhaps the parliamentary assistant would like to comment on the suggestion here that we hold off establishing a college, because I think there is more to this.

The Chair: Mr Wessenger, would you like to comment?

Mr Wessenger: I will turn that over to staff.

Ms Bohnen: The recommendations of the task force on the implementation of midwifery clearly recommended that midwifery be a self-regulating profession. The same criteria which were used by the Health Professions Legislation Review to consider whether other health professions should be self-regulating were applied to midwifery. The criteria were satisfied. We do have practising midwives. Ontario will be establishing an educational program for midwives, as well as an integration program for existing

practitioners. I do not believe this government or the previous government could consider other than the proposals that you see before you.

The Chair: Question, Mr Owens.

Mr Owens: My question is of two parts and the first is to the parliamentary assistant. My understanding is that one of the recommendations of the Interim Regulatory Council on Midwifery is to establish the baccalaureate as the entry to practise, with a time period set up to bring people up to speed. Is that not true? Is that not what we heard this morning?

Ms Bohnen: There are going to be two programs. There will be a basic four-year educational program for people who do not have previous qualifications or experience in midwifery or a related health science, so it will be for high school graduates choosing a university program. In addition to that there will be a pre-registration or integration program for currently practising midwives who have experience and qualifications in midwifery but need to be examined to ensure that they are competent to provide safe and effective midwifery care.

Mr J. Wilson: Just a quick comment. One of the intentions of the legislation is to open up the practice of medicine specifically to women who up to this point have been relegated to second-class status in the health care professions. The question I have is that you make a comment about midwifery not having a track record on which to base self-regulation. I would propose that midwifery has been around for a lot longer than many of us sitting in this room and I am not sure where you draw the basis to make that statement.

Ms McNamara: As an association; I have no problem with midwifery. I agree, but at this point to actually make it a self-regulating organization, without even having the college functioning for a period of time to prove that they are doing a good job, I just do not think is sensible. I do not have a problem with midwifery. Mind you, I do not think you take it as lightly as all that. The births of my children have been relatively easy, but a lot of people have problems and I think it is a fairly serious thing. There is always the crisis situation, and whoever is the midwife has to be ready for that.

Mr J. Wilson: I would further suggest that the medical establishment that you feel should do the training—I think a lot of women have had problems with the attitudes and the activities that are going on. Just recently the College of Physicians and Surgeons of Ontario and its task force on sexual abuse have proved that there are difficulties within that establishment, and maybe it is time to move out.

Ms McNamara: I have a little more confidence in our medical establishment than that and I believe there can be a coming together of the midwives and the medical establishment to establish standards. I am not saying they will not be self-regulating eventually; maybe down the road. I just want them to establish themselves first for a reasonable period of time and have everything set up and then ask for self-regulation, just not right now. I do not think any organization which is not even in effect yet should be self-regulatory right off the bat. I should not say "I"; we do

not feel that way, and we are just trying to protect women, really. We think this is a reasonable and a sensible approach to take and I cannot see why these two groups cannot get together. It almost sounds as if the physicians are on this side and the women are on that side, and that is not the case—maybe a few.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today. As I have mentioned to other deputants, if at any time you feel there is additional information you would like the committee to have, please feel free to communicate with us in writing. Thank you very much.

STEVEN GORING

The Chair: I would like to call Steve Goring. Please come forward. Welcome to the standing committee on social development. You have 10 minutes for your presentation. The committee has received your written presentation—we are receiving it even as we speak. Please begin now.

Mr Goring: Hello, my name is Steven Goring. I am pleased to be invited to present my views to you today. I am not here representing any organization; rather I am here to talk to you as a consumer of psychotherapy. Specifically, my concern is around the assessment or diagnosis clause which, if this morning is any indication, you have already heard a lot about.

I have misgivings that if the legislation as it presently stands becomes law, the way psychotherapy is practised by most practitioners will become illegal. In order for me to be clear about my misgivings, let me first talk about two things: the psychotherapy session and how psychotherapy works.

A typical session with my psychotherapist starts off with me talking about things that are occurring in my life. My therapist is meanwhile taking in information, empathizing with my emotions and looking for areas that I seem not to be aware of or that I skip over. This may lead to questions and, in turn, a dialogue in which there is an exchange of information and viewpoints. It is this exchange that I fear is threatened.

How necessary is this exchange to bring about a positive outcome in psychotherapy? Something many schools of psychological thought would agree on is that the way we view any given situation is coloured by our preconceptions of how the world works. In my experience, the exchange of viewpoints allows me to see a situation through the perspective of another. It is within the context of a strong, supportive client-therapist relationship that I can undergo this sometimes emotionally painful shift in perspective that is the core of how therapy works. My therapist's assessment of a situation is often the catalyst to this transformation.

In order to illustrate how this could be legal, I have a couple of admittedly simplistic examples I want to share. Let's say that recently I have been suffering from insomnia. I tell my therapist I have been tossing and turning without being able to get a good night's sleep and that in the morning I wake up exhausted and stiff all over. I attribute this to my uncomfortable bed and express my intent to buy a new bed in order to get a better night's sleep. Later in the session, while talking about how the spark has

gone out of my life since the relationship I was involved in ended, my therapist ventures her assessment, which is that the insomnia, which can be labelled as a symptom, is caused by my depression, which could be thought of as a disorder, following the recent termination of the relationship. I rely on her conclusion and decide not to go out and buy a new bed. This example is in some ways almost comical and my therapist could cover herself by sensibly recommending that I also seek the advice of the doctor. But my point is that in giving her assessment, knowing that I might rely on it, she has contravened the law.

Let me give another example. I complain of feeling anxious and assume that this is part of my constitutional makeup. After exploring the issue with her, my therapist mentions her assessment, which is that my present anxiety—here, think "symptom"—is caused by a strong jealousy, which could be thought of as a dysfunction, around my girlfriend's starting a new job in which she has to deal with a lot of men. Relying on the therapist's conclusion, I decide to stay in therapy and try to resolve my jealousy. Again, I want to draw your attention to how my therapist has communicated a conclusion identifying a disorder or dysfunction as a cause of symptoms, knowing that I may rely on the conclusion.

1440

I understand that the government is not interested in putting psychotherapists, who are not MDs, psychiatrists or psychologists, out of business. I realize that the intent of the law is the needed and admirable goal of public protection and accountability. I think it can be justifiably argued that the government is not going to go around prosecuting psychotherapists who are properly practising. However, my concern is with the possibility that some psychotherapy client who is enraged with his therapist over some breach of empathy would sue his therapist for malpractice. If this clause is passed as it stands, I suspect it will leave psychotherapists, as well as other professionals, vulnerable because of the ambiguity in whom and what it is aiming at.

I think consumers have a lot to lose if the reality of the therapist's vulnerability is brought home to the psychotherapeutic community through a lawsuit by some disgruntled client. Certainly I could see it having the effect of fewer people being willing to enter or even remain in the profession. This would mean less choice and greater difficulty for the consumer in finding a psychotherapist.

Consumers will also lose if psychotherapists become more selective about whom they work with, screening out those who might be too difficult or risky to work with.

Finally, having a therapist hobbled by worrying about whether he is breaking the law each time he speaks is not conducive to the client's getting his money's worth from the therapy. I am concerned that even the thought of this legislation passing as it stands has a number of therapists I know worrying about their ability to continue practising. As a consumer, I want to acknowledge the invaluable service that I have received from my time in therapy and I hope future consumers will have as much access to good psychotherapy as I have had.

Thank you for your time, and I will be pleased to try to answer any questions.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the standing committee on social development today.

Mr Martin: I also want to say thank you for coming. It is nice to hear from a consumer of health services in our province and to hear of your concerns around this whole question of regulating those who deliver the service.

You confirm a couple of things for me; one, that certainly the consumer is not perhaps as confused or ignorant of the system that is in place as we assume, and that in fact we may be doing something sometimes in terms of setting up regulations that speak to a fear of those who would misuse, rather than an excitement about the possibilities if we allow those who practise in good faith actually to do the job. I sense from you that to do what we are doing regarding the diagnosis clause that we have here would in fact bring more confusion rather than less confusion. Is that correct?

Mr Goring: Yes. I think that any confusion it brings within the community of psychotherapists not covered by the diagnosis clause would affect the consumer. I really support the thrust of this legislation, to try to get the charlatans who are out there, but they get a lot of press and I thought it was important to present the other side too, which is that this legislation might catch a lot of good people out there who are doing good work.

The Chair: Thank you very much. We appreciate your appearing before us today.

JANE CHAMBERLIN

The Chair: Is Jane Chamberlin here? Please come forward. You have 10 minutes for your presentation. We ask if you would leave a few minutes for questions from the committee. Please be seated, and welcome to the standing committee on social development.

Ms Chamberlin: I am pleased to have the opportunity to appear today. I am present as a private individual, but one who has served as an appointed member to the Ontario College of Pharmacists for nearly six years, so I will speak mainly to the issues of the effectiveness of public members on the college councils.

I strongly support increasing the numbers of public representatives on the colleges. I would say, however, that the effectiveness of the public members is limited not only by their small numbers but by their personal skills. A professional representative, by virtue of his professional expertise alone, has something to contribute to the work of the college. Only with intelligence, strong views and the confidence to express those views will an appointed member be prepared to contribute meaningfully. If the Legislature increases public representation to just under half, without the ability—and I suggest that is currently the case—to recruit capable individuals, it runs the risk of creating large, unwieldy governing councils to no purpose.

I wholeheartedly commend the current government for increased attention to the qualifications of proposed appointees. A very high level of competence among appointees will be required to provide a net benefit to the

colleges and to the public they serve if their representation is to be so markedly increased.

In sum, I would recommend that the numbers of public appointees be increased beyond the levels proposed only if there is a strong commitment to ensuring their competence through the selection process and through effective orientation and continuing training programs.

I would suggest a couple of possibilities for widening the possible scope of the talent pool for public representatives.

First of all, as it stands, I think appointments are currently limited to the rich, the leisured and those who are willing to make personal sacrifices to serve because of the demands on time and the low remuneration. I would suggest that in order to increase the likelihood of an employer allowing an employee to serve, and therefore getting representation from all those who are employed—obviously, a vast majority of adults—employers should receive a tax credit or charitable donation receipt to compensate for lost employee time. These enhanced benefits should also be extended to the individuals who serve, if the government feels unable to increase the levels of the honoraria.

Members of the public service of Ontario are excluded from service, and while I understand the principle of that, I wonder if it has not been extended a little too broadly. Clearly, those who work for the Ministry of Health must be excluded, but it would be, one would think, relatively easy to persuade other public service employers that there was a benefit to having their employees serve.

Committee representation: I feel very strongly about this. I think that this is one of the ways you can make the biggest difference to the effectiveness of public members, and that is, if you are increasing the number of public representatives on the councils of colleges as a whole, it makes no sense not to increase the representation on committees, where the bulk of the work is done. It would only be as a member of college council that you would recognize that this serves to isolate public members. We never see how the other public members function except at meetings of the committee or the council—I mean those two terms interchangeably—so if an issue strikes you as perhaps having a particular public interest benefit or slant, it is often very late on before you pick up on that and you have no one who comes from that similar background to talk about as those issues are in committee.

I would suggest that if you increase total representation to just under half, you mandate two public members on each statutory committee, and that if you increase it to the point that it is now in the legislation, you mandate an increased representation on the executive committee, and I would be delighted to talk to anybody about that further.

1450

The terms of service: I think you will all recognize that on the college councils there is a tendency to think of there being two classes of members. That serves no one's purpose. Once you are there, your job is the same, your task is the same. You come from a different background, but you have the same purpose. So continuing distinctions among those members only serves to continue to distinguish between two classes of members. I would suggest there is a strong benefit on the limitation of term, and I would suggest that

this benefit extends equally to professional representatives and public representatives.

Finally, and I will read this verbatim, it is very difficult for any group, even a group of professionals, to understand that they are to elect a representative who will not represent their issues. You all are imbued with the notion of an elected representative representing the issues of the people who vote for them. That is not the case on these colleges. They are sometimes there to act directly in contravention if the public interest contravenes the professional interest of the members, which it does not often do but which it occasionally does. It is very hard for those professional people to understand fully and to support fully the role of the colleges.

Current election practice at the Ontario College of Pharmacists is two-year terms. This makes the members very sensitive to the fact that they have to be re-elected when they are dealing with dicey issues.

There has been a very recent clear example of such a dicey issue. At the moment, this has meant that current members of the college council who voted, in the public interest, to remove the sale of tobacco from pharmacies have done so under the watchful eye of an electorate. At least four members who voted in favour of that move have now lost their seats and have been replaced with individuals whom the pharmacists feel will better represent their own interests. This is unfortunate, inappropriate and decreases the likelihood of effective self-government. You will note that it is not the council members who failed to act in the public interest on this case, it is the electorate.

I would suggest that, assuming it is necessary to have an elected rather than an appointed council, the colleges should be strongly encouraged to extend the term of office to three years—I understand this is not directly before you today and it is an indirect responsibility on your part—and that once elected, a member who has fulfilled the rule requirements should be eligible for a one-term reappointment by the council itself.

Additionally, colleges should be encouraged to develop strong orientation programs for both professional and public members to ensure that they are fully aware of their role and of the seriousness with which the colleges attend to the duty to act in the public interest. I solidly expect that the College of Pharmacists will be actively engaged in developing a very strong orientation program under the current circumstances.

Since my term ends in October, I will shortly be a retired public member. I would welcome the opportunity to assist or advise any group which has responsibility for increasing the effectiveness of public members on the councils of colleges of the regulated health professions. I thank you for the opportunity to be here today and welcome your questions if you have any.

The Chair: Thank you very much for your excellent presentation.

Mr J. Wilson: Just a quick question. Are you envisaging then that the College of Pharmacists will have difficulty perhaps attracting people to fill the nine slots that will be filled by the Lieutenant Governor in Council?

Ms Chamberlin: I would suggest that the appointment process at the moment indicates, from the view of the

receiving body, that there has been limited success in attracting the kinds of people who are fully capable of actively participating in the affairs of the college. While I support in principle the opportunities that would come from increasing public representation, if you have only warm bodies in chairs, you are making a heavy, less functional body to no aim.

Mr J. Wilson: I appreciate the frankness of your presentation, because it seemed to me from the beginning that the decision to increase the lay members of councils was indeed a political decision. Having been a former assistant to the Minister of National Health and Welfare, I tell the government—and I have mentioned it before—it is darn difficult to find the hundreds of people you require for these councils, with the enormous turnover, very often.

Having said that, the purpose, of course, is to try to give better representation and balance to the public. I certainly appreciate your comments and welcome your research.

Ms Chamberlin: The interests of social justice aside, and the interests of the effectiveness of the body being my motivation, I would suggest that representation can be achieved, but it should not be achieved at the expense of effectiveness. You can encourage effectiveness by continued training of professional and public representatives in their role. You are going to have huge numbers to find when this legislation goes through.

Mr J. Wilson: I absolutely agree. Is there any training in place?

Ms Chamberlin: Yes, there is. The ministry, since the days of Murray Elston, has initiated a two-day workshop for public members. It is good, it is well intentioned. It is not adequate, and it certainly will not be adequate with the multiple new members.

Aside from the training, you need to be able to draw from a better pool. You have retired people, homemakers, wealthy people and people who are dedicated to public service who are willing to sit on these bodies and who have the combination of time, skills and understanding of the processes. You have to have a gutsy person in the chair to get up and running quickly and feel capable of dealing with professional issues. There are lots of people who never make it to that level of confidence that they can essentially argue or that their view is as valid as the professional members' view in a self-governing body. You need more bodies to do that; that will help, but you need more capable bodies too.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today.
1500

NORMA McLAUGHLIN

The Chair: I would like to call Norma McLaughlin. Welcome to the standing committee on social development. You have 10 minutes for your presentation. I would ask you to address the committee now and leave some time for questions, if you would.

Ms McLaughlin: I appreciate this opportunity to make a presentation regarding the diagnosis clause.

My presentation is based on candida albicans, from which I suffer, along with thousands of other people, and the kind of help and care I received from the medical profession and alternative care people.

What is candida? It is yeast. We all have yeast in our bodies, the good and the bad yeast. If the bad yeast overcomes the good, an imbalance results in yeast overgrowth. It becomes a fungus and is called candida albicans.

You often hear Epstein-Barr virus—chronic fatigue—or myalgic encephalomyelitis, or ME—it is better for me to say ME; I cannot pronounce that word—mentioned along with candida. Herpes zoster virus, which is shingles, enters our bodies via chicken pox. Later on in life, we sometimes break out in shingles from the virus when our immune system is low, which means we have a candida problem. You can have a problem long before you get full-blown candida albicans like I have, and most of the time you do not know you have it. Herpes EB and herpes mononucleosis are activated by the candida. ME is supposed to be worse than Epstein-Barr virus. I do not know for sure, because I have never seen anything in print, and I think EB is much worse than mononucleosis. I have slight bouts of herpes zoster—shingles—and brain damage caused by the toxins from candida, which makes it difficult for me to write. I have a constant upset stomach, which is very common to people with a candida condition, severe constipation and athlete's foot.

I became aware of failing health in 1989 with the following symptoms: Frequent and urgent urination, acid stomach, feeling of lethargy and loss of appetite. Also, I was not too constipated at that time. I was starting to have trouble and could not quite understand why. I realize now that it was a candida problem.

I consulted my own physician. He ordered an ultrasound, which showed a small hernia. That was not much help. Then another doctor in town ordered a barium enema. I did not bother with it because I did not think it would help.

Anti-aging program: I heard about a doctor conducting an anti-aging program in Toronto. I decided to try that. He tested my urine, stool, blood and everything and put me on the program. I was on it for some time and did not seem to be getting any better. I developed athlete's foot and he knew I had candida. Blood tests, etc, were ordered again.

He prescribed an antifungus drug, Nystatin, and a diet of water and vegetables. I could not eliminate the debris caused by the antifungus drug when it killed the yeast, and I became severely constipated. I called the doctor in Toronto and he advised colon irrigations, of which I had several, but did not feel much better.

As soon as I found out I had candida, I told my own doctor on the advice of the Toronto doctor. My doctor said to me, "That is a lot of horse manure, this candida thing." A lot of doctors do not believe there is such a disease. He prescribed stool softeners, which were not any help at all. It is written in this book that I mention here, *The Silent Killer*, that you have to be very careful when you are prescribed this antifungus drug. A lot of things can go wrong and some tragedies happened. This book was written in 1988. The medical profession, both psychiatrists and medical doctors, issued statements to the press that it was all in our heads.

This caused a lot of hardship for some people because their families and friends turned against them. They did not believe there was such a disease, because we were half-sick and half-well, the walking sick. Some of us were able to get around; others were unable to walk very much, suffering from Epstein-Barr, which attacks the muscles. Some people seem to have Epstein-Barr with candida secondary, which is the worst. I am the other way around.

The chiropractor, homeopath, acupuncturist—that is one person. Also, I was advised from another patient suffering from candida to see this care giver because he helped her. He had a good knowledge of candida, was very understanding and helpful with his advice.

His tests on a computer showed that none of my systems were working—digestive, kidney, etc. He gave me laser acupuncture treatments for all systems and I improved, put on a little weight and was able to eat. I still need a further treatment. He only does one thing, so I sought the treatment of a naturopath. He gave me a computer test of the whole body, and the printout showed the debris was lodged in my colon, especially in the ileum. He believed in building the body to fight the disease and did help a little, but he was not candida conscious and did not know how to remove the debris. He did do a lot of good for my kidneys. He reduced my acid from 300% to 100%.

Iridologist: I went to her because I thought she would test me for allergies. She confirmed there was debris in the right colon and wanted to administer some herbs and put me on a fast, but I declined because I did not think she was the person to do this.

Another naturopath: Thinking it would help, I tried to find someone who knew about hydrotherapy, which is water treatment. I had read about this in different magazines, in different literature, but she did not know much about it, except to use hot and cold compresses. She advised me to eat as many green, steamed vegetables as possible to go through my intestines. My bowels moved, but I still was not satisfied and did not feel well.

In the spring, I drank a mouthful of hydrochloric acid by mistake. I was rushed to hospital, where they gave me first aid, ran an IV and also took an ultrasound. The doctor who did the ultrasound reported to my doctor that there was an awful lot of stuff in the right colon. My doctor also noted that my stomach was hard, but did not know what to do other than prescribe some suppositories. They were no use at all.

Colon irrigation: I phoned around and found an RN who does colonics. I called her and told her how badly I was impacted. She told me she had a lot of experience and could help. She found that my transverse colon was all impacted, which probably accounted for my stomach being hard. I have had a month of treatments, colon irrigations. She has made a study of my case. She ordered hot castor oil compresses three nights a week for an hour and a half, followed by some olive oil to drink on the fourth day, and drinking lots of water. She has been successful in removing quite a bit. It should take possibly another three months to get it all out.

Between her and the acupuncturist, I feel I am getting good care, along with the knowledge I have gained from studying my own case, but I should have a stool, blood and

urine test. At an appointment with my doctor, he took my blood pressure, weighed me, did not listen to a word I had to say about my colon, and stood up for me to leave. In a few minutes, I was outside his office and had not told him about these tests.

This is my story. We have an association in Collingwood of these people. There is also one in Orangeville, Orillia and Owen Sound, probably in every town if you went to it, lots of them in the city. There is story after story of doctors rejecting them when they cannot diagnose this candida, which also leads to Epstein-Barr. Some are worse off because they do not study their own cases or consult other care givers. Some are prescribed tranquilizers by doctors, which is the very wrong thing to do.

I found that in different books. This book, *Candida Yeast Infection: The Silent Killer*, by Rupert Bebee of the Healthology Association of Canada, has input by several doctors. I got a lot of information by it. He thinks alternative care and the medical profession should work together. Both are needed.

The last paragraph is my own comment and is not from the book. The medical profession has come out badly on this disease. They feel confronted. It is a complicated disease and they do not want to get involved. Each patient should study their own case and be equally responsible. Each is different because we are all different with different biochemistry and different constitutions. I have studied three books by medical doctors, three books by naturopaths, and use the knowledge from both.

I am satisfied with my alternative care givers, but I also need a medical doctor. Finances have been very stretched for me. I have paid all my own way to go to the other care givers and I have had to rent rooms and do other things to get by. There is one thing that both these doctors can do who found my colon is impacted, and that is give me a colostomy.

The Chair: Thank you very much for your presentation. The committee appreciates you coming before them today and bringing us your perspective, and we want to thank you very much. If there is any additional information you think would be helpful to the committee, please feel free to communicate with us in writing. Thank you very much.

1510

BOARD OF DIRECTORS OF DRUGLESS THERAPY AND NATUROPATHY

The Chair: I would like to call now the Board of Directors of Drugless Therapy and Naturopathy. Please come forward and begin by introducing yourselves. You have 20 minutes for your presentation. The committee has received your written brief; please start your presentation now.

Mr Spring: My name is Jim Spring and I am the chairman of the Board of Directors of Drugless Therapy and Naturopathy, the regulatory board for the naturopathic profession in Ontario. My colleague, Rod Gratis, is the vice-chair of the board, and will be presenting with me. Thank you for the opportunity to address you today. Our presentation will be informative, very brief and to the point.

Mr Gratis: Naturopathic medicine has been constantly regulated in Ontario since 1925. In that time, there

have been well over an estimated five million patient visits to naturopaths by the residents of Ontario, and from all of them there has never been a reported serious injury or death as a result of those treatments. In other jurisdictions, untrained persons claiming to be naturopaths have caused serious injury and even death.

This enviable record is purely and simply the result of competent and responsible self-regulation of professionals who practise what they were trained to do. Regulation is absolutely necessary to protect the public.

The standards for entering the profession include university pre-medical training, a minimum of three years, followed by four years of dedicated, full-time, naturopathic education and, upon graduation, passing the rigorous board examinations. That is a total of seven years post-secondary training as the minimum, and most of us have more. These requirements have done an excellent job of protecting the citizens of Ontario as they receive safe and effective naturopathic treatment.

As the board scrutinizes and regulates its practitioners, it also constantly strives to further improve the ways it can protect the public.

For your reference, the traditional scope of practice of naturopathic medicine includes botanical medicine, clinical nutrition—which is much more than the four basic food groups; it includes the actual relationship between nutrition and disease—diagnosis, oriental medicine and acupuncture, homeopathy, manipulation and some physical modalities, all done safely and effectively for over 60 years of regulation in Ontario.

The Board of Directors of Drugless Therapy and Naturopathy does not live in a vacuum. We communicate regularly with other licensing jurisdictions and organizations in Canada and elsewhere. We stay abreast of the constantly changing technology and research showing the safest and most efficacious methods for procedures and treatments to be accomplished and make certain that Ontarians receive the benefit of those.

Interestingly, other jurisdictions that maintain the effective principles of self-regulation of naturopathic medicine, as practised here, also have excellent records of public protection.

In closing, the naturopathy regulatory board urges you to retain effective regulation for naturopathic medicine, making certain that the traditional scope of practice, which is demonstrated safe and effective both here and elsewhere, be retained and regulated in its entirety.

Thank you, Madam Chair. We have left lots of time for questions.

The Chair: Excellent presentation. Questions from committee members? Thank you very much for your presentation. I know the folks following you are the Ontario Naturopathic Association. Perhaps they will join you now and then if there are additional questions that are raised they can be answered.

ONTARIO NATUROPATHIC ASSOCIATION

The Chair: The Ontario Naturopathic Association, please come forward. You have 20 minutes for your presentation. Please begin now.

Ms Wales: My name is Pat Wales. I am a naturopath and I am the immediate past president of the Ontario Naturopathic Association. With me here today is Dan Labriola. He is also a naturopath and is the director of government affairs for the association.

The Ontario Naturopathic Association represents naturopathic practitioners in Ontario. Our mandate is to maintain the safe, effective and complete practice of naturopathic medicine in Ontario. At the back of your handout there is a green brochure. This brochure outlines the practice in Ontario. I will not go into the details, as we have just heard about those from the regulatory board. I will quickly review, however, a little of the history that has led us to where we are now, after which Dan will outline our specific concerns for the future. We want to be brief and to the point.

In 1986 the HPLR and Health Minister Elston felt that the naturopathic profession had not adequately met the criterion for "body of knowledge." This was one of the nine criteria the HPLR had set for self-regulation of professions. This particular criterion is considered especially important, for without it a profession is not considered capable of disciplining errant members and thus protecting the public from harm.

Following Minister Elston's announcement, the naturopathic profession proceeded to provide new information to the ministry about "body of knowledge," and more. As a result of the new information and a careful review of all the facts by then-Minister Caplan, it was decided to continue the regulation of naturopathic medicine. But since the advancement of the act by this time was on the fast track and ministry officials felt there was not time for our profession to be included in the new law, it was decided that we would be the first profession to apply to the new advisory council after enactment, and in the meantime we would remain continuously regulated under the Drugless Practitioners Act.

As the regulatory board before us has stated, our history for self-regulation and protection of the public interest has been excellent, and we aim for it to be even better in the future. Ever-increasing new outcome studies for botanical medicine, clinical nutrition, manipulation and the other modalities we use are enabling doctors of naturopathy in Ontario to provide even better treatments for the 300,000-plus patient visits we see each year.

It is of interest to note that the only college training naturopathic practitioners in Canada is located here in Toronto, in Etobicoke. The Ontario College of Naturopathic Medicine is one of only three in North America, and we are very privileged to have it here in Ontario. The entrance requirements include three years of university pre-medical training. The four-year full-time program includes clinical training under the supervision of regulated naturopathic professionals.

I would now like to ask Dan to describe our specific concerns for the future.

Mr Labriola: Bill 43 is certainly a quantum leap forward in the omnibus health care legislation and pioneers new methods and new processes for managing health care professions. I think it is safe to say that Ontario is not only leading the country but perhaps leading the world in this kind of regulation. But as with all new and noble ventures,

which this certainly is, I think we need to be certain we do not add any ingredients that cause this legislation to do something other than protect the public interest as planned.

Before I go on with my specific—which will be very brief—comments about it, I do want to mention one thing. The naturopathic profession, when we apply to the advisory council, we are confident that we are going to go through this process in a really effective and efficient manner. We do not expect, at least from our initial contacts with other professions, that there is going to be a lot of turf-grabbing or the other kinds of things that come with health care legislation, although God only knows, politics, if nothing else, is a surprise.

The Chair: There are probably a lot of members around this table who would agree with the last statement. Please continue.

Mr Labriola: What I would like to do is spend a moment and discuss what is new and different about the application process, specifically as our profession and other professions will go through it, and contrast that to the experience that the professions now in Bill 43 had experienced during the review.

The most obvious one is that we will be one profession in a fish-bowl. We will be there by ourselves, and this is in contrast to the review process where all of the professions were on relatively equal footing. We will be one profession absorbing the costs and burdens of the application process, the only one at the time. We will be in a position where we are critiqued by all of the other professions, and in fact maybe even having some of our turf attacked—we do not think so, but that is an unfortunate fact of life in health care—and this, once again, in comparison to the review process where all of the professions were relatively safe and equal in their approach to this process.

To put it succinctly, I think the profession that applies to the advisory council after the enactment of the bill starts out at some disadvantage, at least in those areas I discussed. I think the solution, though, is a simple one and it may be one that is already contemplated, but I feel the need, since we are going to limit our comments to that particular area right now, to at least go over them and express to you how we feel. We are hoping that this committee, and perhaps the ministry, will make a statement or a position that they are in fact enforced.

The first one is that the process remain accessible and reasonable to all professions, especially small ones. I think it goes without saying that a perfectly viable and useful health care option and profession in Ontario could be removed as a choice to the residents of this province by no other means than the paperwork level and the legal costs and other things involved in the application process becoming so onerous or so large that the profession cannot or does not know how to deal with them.

I think it is important that all requirements remain transparent and predictable. By transparent I mean that every requirement be absolutely clear as to what is expected, how it is expected, and when it is expected. I also think it is important that decisions be discussed during the process rather than after the process. There should be no

surprises in the process—once again, transparent and predictable. It may not change the outcome, but it will certainly allow our profession and other professions to proceed in an empowered way. I think that has certainly been the objective of this legislation.

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Some limit on the amount other professions can lobby the advisory council and the ministry will be important. This is to minimize the turf-grabbing activity. I do not suggest that the council or this government or anyone is going to be susceptible to a lot of turf-grabbing activity. I do not think that has been the case; I do not think it will be the case. But by allowing a lot of lobbying and a lot of this kind of thing going on, it takes our valuable concentration and time away from the more important issues at hand.

Fourth, I think it is important that we recognize the uniqueness of professions, especially the naturopathic profession. If you try to understand naturopathic medicine by looking at us from a familiar model such as medicine or dentistry or chiropractic or whichever you choose, I think it is safe to say that you will never understand us. You will not understand the principles by which we operate; you will not understand how we achieve the results we achieve.

Carrying that a little further, I think the view of professions as a whole, and especially naturopathic medicine as a whole, is a very important concept for us to keep. You can almost compare the profession with the human beings whom we treat, and that is, the whole of the profession is much greater than the sum of all our parts. It is how the parts fit together, it is how they act, it is how they interact with themselves and with others that is very important. The very safest practice of naturopathic medicine is when it is practised as a complete entity. If the system were to inadvertently cut off an arm or a leg of our scope of practice, you would lose more than that one modality; you would really lose the balance and the interaction and the motion and the effectiveness of what is there.

Our concern about this, actually, may not be as great as the concern of some of our patients and practitioners right now; I am sure you are going to hear more about this. But I think it is at least worth enough mention that we go on record with our feeling about this. Let me, before I go any further, say another thing. We believe, and have always believed, that this law has been written by some very skilled and very reasonable people, some of whom are here today, and there is no question that it was intended to be fair. We have no doubt about that. We have never had any doubt about that.

I think it is also safe to say that any piece of legislation as large and as complex as this one will, if special steps are not taken, automatically favour the biggest and the strongest. It is a variation of Murphy's Law, and I think what I am suggesting here is that care be taken rather than that the initial intent being in any way faulty.

In summary, I would like to request several things of this committee: first of all, that we do in fact take special care to ensure that the playing field remains even for all professions in the implementation of this law, especially small professions. Second, I think we need to make certain that the sheer size and complexity of this act does not in

and of itself and inadvertently overwhelm or undermine professions that are trying to operate within it. I am sure it will be inadvertently, and I mean that. But the fact is, this is a very large, complex act and we certainly would not want to see it, in effect, remove freedom of choice.

To put it another way, if we are going to be the only fish in the fish-bowl, and I think we are going to be the only fish in the fish-bowl when this starts, we would like you to at the minimum remove all harpoons from the first row of onlookers. We would like to make certain that the hoops we have to swim through are consistent with the public interest and are not expanded or retracted or changed in any way. Finally, if we are going to allow anything to be thrown into the fish-bowl and left floating, let's just make sure it is organic fish food.

Thank you. That concludes my comments.

The Chair: Thank you very much for a very interesting presentation. It is the first that has such graphic analogies.

Mr Jackson: I have some technical questions of the ministry to just explain the process. This group is included within the legislation for purposes of clarifying that they are not going to be deregulated, so this brings you within the ambit of the legislation. But we do not have a specific piece of legislation which sets out, as for all the other groups—

The Chair: I think the parliamentary assistant would like to explain the status and process, Mr Jackson.

Mr Jackson: I have some technical questions about the scope of practice, which we are discussing with some groups, but we are not in a position to discuss scope of practice with this group.

The Chair: You are correct. There is no piece of legislation before us today, except for the omnibus bill which they are speaking to.

Mr Wessinger: I will just refer that to staff counsel but, as I understand it, naturopaths are not directly covered under this legislation. They make application under—

Mr Burrows: Under this package it is true that naturopathy is not included. However, at first reading and again at second reading it was confirmed that the profession of naturopathy would continue to be regulated under the existing law until such time as the matter of its scope of practice could be reviewed by the regulatory advisory council.

As a point of clarification, I think maybe it addresses some of your concerns because the advisory council, as proposed in this package, would be composed of laypersons. There would be no bureaucrats and no members of the health professions sitting on the advisory council. Certainly, in developing the processes and procedures, that will support that group. It is anticipated that the process would be as open and transparent as the review process itself and perhaps even more so.

Mr Jackson: Conclusions always fascinate me more than processes. My concern is that we do not have a specific piece of legislation to replace the one we are leaving; presumably at some point we will. This group will not have the access to, say, this committee as all other groups do that have been advised that they are to be included.

The Chair: As I understand the legislative process, from my experience, which is similar to yours, Mr Jackson, the process would be for the government to table legislation at some future date, which could then be referred to committee for scrutiny. That that would be normal legislative process.

Mr Jackson: That is my understanding as well. I guess now we will ask the deputant. Is it your understanding that this the horizon you are looking towards, that you could anticipate legislation, as opposed to a regulatory framework, which could be covered by order in council? It is possible to rescind your legal coverage but have you covered by regulation?

You have been promised inclusion, but have you been promised inclusion with a proper bill setting out your scope of practice, or have you been told you will have scope of practice that could lead to basic regulations?

Mr Labriola: I am not sure exactly how to respond to your question. My understanding of the process that is coming forward is that we would be reviewed by the advisory council, at which time a recommendation would be made to the Minister of Health, and the ministry would then table legislation that would include our scope of practice and all the other issues, ostensibly in a manner consistent with Bill 43.

Mr Jackson: That is the point I am trying to get on the record, Madam Chair.

The Chair: For your information, Mr Jackson, in the package of material that was presented to you, you have statements on first and second reading, particularly by the minister and the former minister, which laid that process out and also made the commitment that regulation would continue under the Drugless Practitioners Act. I believe that is in the statement in Hansard.

Mr Jackson: I want to be assured it was a public statement. I was not here for the minister's presentation but, in my view, its continuing in a regulatory framework does not allow you the access to the process I think you are indicating you would wish to be part of.

The Chair: Those statements were made in the Legislature.

Mr Jackson: Yes, that is fine. I just wanted to make sure that was on the record. I have used naturopaths with great success and I appreciate it. I have also taken courses of naturopathy in the state of Virginia and I certainly was one who supported your regulating for access in this province. I am pleased that you have come this far and look forward to encouraging you in that regard.

The Chair: Thank you very much, Mr Jackson. There being no further questions, thank you very much for your presentation. If in the course of these hearings you feel you would like to submit anything further, please do so in writing.

JENNIFER GIAVEDONI

JANE DELY

The Chair: The next presenters, Jane Dely and Jennifer Giavedoni, are making a joint presentation. Please come forward. The committee has received your written

communication. We ask that you take the next 10 minutes to give us your presentation and leave a few minutes for some questions at the end.

Ms Dely: Madam Chair, dear committee, we would like to thank you, first of all, for taking the time to listen to us today. I would like to introduce myself. I am Jane Dely. I am a certified dental assistant. I am a graduate of a community college dental assisting program. I am also a member of the Brant County Dental Assistants Association and the Ontario Dental Nurses and Assistants Association. Jennifer and I are two dental assistants who have worked in several dental offices over the last 11 and 9 years respectively.

Ms Giavedoni: My name is Jennifer Giavedoni. I am a member of the Dental Nurses and Assistants Association of Hamilton and serve on that executive, as well as being a member of the Dental Nurses and Assistants Association of Ontario. I have attended a private college for my training in dental assisting and have been certified for eight out of the 11 years I have been a dental assistant.

The existing legislation allows us to perform no intraoral duties. However, we feel there are many intraoral, in-the-mouth, services dental assistants can provide that do no harm, therefore we believe the proposal to leave these unlisted and in the public domain is correct and in the public interest.

Ms Dely: In Ontario, the practising dental workforce consists of approximately 5,000 dentists, 2,000 hygienists and 1,000 denturists. Of this group there are 10,000 dental assistants. This new legislation you are proposing would therefore better than double the useful workforce. This would certainly make for smaller increases in dental costs in the future.

Ms Giavedoni: In all of Canada, only Ontario and Newfoundland have not yet modernized and expanded the duties of dental assistants. We, and the literally hundreds of assistants we have spoken to, agree with this proposal. These are ordinary working people who are dedicated and want to be more useful in the community.

Ms Dely: At the present time we know of numerous assistants who are going out of province to British Columbia, Manitoba, Alberta and all the other provinces to upgrade their dental assisting skills. They are coming back with a level 2 status, or a PDA status, which is a preventive dental assistant. Ontario does not have this level as of yet. They are going out of province at an expense to them.

Our presentation has been brief today. We worked this morning and came down. On behalf of Jennifer, myself and all the other assistants we have spoken to, all we want to say is what you are proposing is good and should have been done a long time ago. We want to thank you for listening today.

The Chair: Thank you very much for a very good presentation before the committee. Any questions? It was very clear. If there are any questions members have in the future, I know they will be able to contact you. If you can think of anything further that you think the committee should know, please feel free to communicate with us in writing in the future. Thank you for appearing today.

The committee adjourned at 1534.

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Standing committee on social development

Comité permanent des affaires sociales

Regulated Health
Professions Act, 1991
and companion legislation

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Thursday 15 August 1991

The committee met at 1002 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi de 1991 sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

COALITION OF UNREGULATED PRACTITIONERS

The Chair: Good morning. Welcome to the standing committee on social development. The committee is now in session.

I would like to call first on the Coalition of Unregulated Practitioners. Please come forward and introduce yourself. The way the committee has been working, I have been asking everyone to leave a few minutes at the end of their presentation to allow for some questions if they wish. You have 20 minutes in total. I would ask that you begin your presentation now. Please have a seat so that Hansard can record everything you say.

Mr Evans: Our submission which is before you is very lengthy and I am not going to read it; it would take all day. Fortunately most of you have received and perhaps read most of the materials, but it is useful to have it all in one package.

Our main proposals as a coalition are four alternative solutions to the diagnosis-clause problem, and two supplementary recommendations. I am going to mention these first and then set them aside. These supplementary recommendations are designed to reduce the likelihood of prosecutions arising from turf or ideological considerations rather than from the need to protect the public.

One of them is to add to the duties of the advisory council a screening process. The other is an interpretative provision which would be in the legislation for the courts to apply when prosecutions are brought forth. I do not see any reason why both of these could not be introduced, but they are also alternatives.

I should mention, concerning the screening, that it would only be where someone tried to prosecute under the RHPA that the screening process would apply. A civil suit or something under the existing criminal law would not have to go through the RHPA.

I would stress that both of these are needed, whatever solution you arrive at concerning the diagnosis clause. These are mechanisms to restrain the misuse of a new set of laws, and there is still the problem of trying to get the

best law drafted that we can. Also, these recommendations apply to all the prohibitions; they are not just relevant to the diagnosis clause.

In the report itself, there is a lengthy introduction, and then sections A, B, C and D. A explains what the coalition is; B, what is wrong with the first controlled act, and I will be going on now to talk about what is wrong with the first controlled act. In the coalition we have come to emphasize the need for clarity concerning what is wrong with it so that you on the committee would realize it is a serious problem; and also so that in your deliberations concerning what to do about it, whatever you come up with, we will need to deal with the problem.

In the College of Physicians and Surgeons of Ontario, the view, the last I heard, was that this diagnosis clause—it is still called that often, though the word does not appear—would be ineffective in ensuring successful prosecution. From the point of view of the coalition, it would put responsible unregulated practitioners in legal jeopardy. It is possible for these perspectives to be true, as we have seen concerning the harm clause, where there was—there seems to be a consensus now—kind of an impasse. I have hopes in regard to the diagnosis clause, however, that a solution may be findable.

The coalition concern is that they not be turned into a test case. It is not primarily a concern about successful prosecution; they might indeed eventually win if prosecuted. What sends shudders down the backs of the people in the coalition is the idea that the ambiguous meaning of "disorder," "dysfunction," and "cause of symptoms" can be left for the courts to decide, as people do not want to become a test case, especially when the wording is ambiguous.

The prosecution that is feared is not from the government. For some it is a fear of prosecution from one or other of the colleges, but it is mainly a disgruntled client who has the aggressive will and either personal wealth or the backing of some ideological group. For example, some pastoral counsellors could see themselves as vulnerable to a campaign by either a pro-life group or a pro-choice group in a test case, even if the person has acted very responsibly, simply doing his job. That is the problem. It is not that the coalition is advocating irresponsible activities on the part of the unregulated.

Our concern with regard to your committee is that because of the understandable urgency to pass the RHPA, and because there are bound to be some flaws in any alternative proposal, you may feel moved to pass it either unchanged or with only a kind of tinkered revision. In section C, the coalition rejects a number of tinkering solutions, including some that we presented ourselves in the past; we were not thinking as clearly as we might.

In particular, I draw your attention to one of these solutions. According to this, you retain the first controlled act

as is, then you define "assessment," and then you explicitly permit it, put it in the public domain for both the unregulated and the regulated.

The problem with this approach, as I have now come to see, is how do you define "assessment"? You need to include in the definition of "assessment" what responsible regulated and unregulated workers do, which is, from time to time, to identify some disorders or some dysfunctions as the cause of symptoms. But if you put that in the definition of "assessment," then where is your contrast with the wording in the first controlled act?

If you use a vague expression like "evaluation of a physical or mental health condition"—there is something like that in the Health Professions Legislation Review—then that restricts unduly what many unregulated and regulated people do. It is pretty close to describing symptoms. Of course, many go far beyond that, and rightly so.

In section D we have four proposals, all of which involve deleting the first controlled act and then taking up a different approach. The first proposal is to prohibit misrepresentation of title and to rely on this and public education concerning title. The second, a relatively new proposal from the coalition, is to restrict potentially dangerous communications by reference to competence, a competency in communication approach. The third and fourth approaches involve restricting the unregulated by referring to the existing law of prohibiting the practice of medicine without a licence.

This third proposal has been very attractive to most mental health workers because they have not felt any threat from the existing legislation prohibiting the practice of medicine without a licence; this in contrast with some of the natural healers, who have felt not just prosecuted but persecuted under the existing legislation. This approach, by bringing in a reference to the prohibition of practising medicine without a licence, even if only in relation to the unregulated, I have been told seems to be contrary to the general spirit of the legislation, which was to abolish that prohibition and replace it by the set of controlled acts.

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The coalition as such does not endorse any one of these exclusively. All of these—I want to emphasize this—are regarded as better than the first controlled act as it stands now. That is why we are bringing them before you. We do not endorse only one, because there are differences within the coalition, and also because it is a public policy judgement, up to you as MPPs representing the public. I am not saying that just out of a polite deference; I really believe this. I think there are profound public policy issues at stake in regard to the choice you eventually make.

Proposal 1, prohibiting non-members of a college from saying that they are members: I am not clear whether the drafting is clear enough concerning this. I know some of the regulated are concerned whether it is sufficiently clear. That is an issue that no doubt needs to be looked into. Also, some professions may both need and deserve an exclusive clear title. For others it is a controversial issue, I gather. In the case of the psychologists—this is only my personal view—it seems to me they have a case for at least not having their clarity of title reduced by the current legislation.

Who proposes this overall approach? There are some MPPs I have talked to, some responsible regulated professions individuals and some responsible unregulated. Among the unregulated you will be meeting Ron Dugas, who I think is the clearest spokesman for the natural healers. He will be presenting something in Ottawa. The last I heard, this is what they were proposing.

What is the reasoning behind this? It is in a broad sense philosophical that there are limits on the extent to which the state should use the law to protect the public from making foolish mistakes in regard to advice concerning health, and a view that the consequences of introducing a law to try and do this are worse than the consequences of not having a law. That is a public policy decision.

I want to emphasize that the clarity concerning the ban on misrepresenting title is not an alternative to the other proposals from the coalition. They all need this too. Proposal 1 is to rely solely on this in public education and nothing else. All the other proposals assume that is not enough and they add something.

I am going to spend most of my time on proposal 2, because it is new, not because I can claim it has wide backing in the coalition. There has not been time for many to hear about it. On the whole, I have had positive responses, but also I think there is a possibility this may be the approach that can gain consensus. For one reason—this is a relevant consideration, although I think it is not the only consideration—it is closer to the Alan Schwartz HPLR approach, that is, you identify a potentially dangerous act, you describe it without reference to the practice of medicine, but here there is a difference. You cannot list this, as I see it, among the controlled acts because it is not like a piece of surgery, where you can say only a person who has such-and-such authorization should be able to enter in the ear beyond a certain point.

The potentially dangerous communications vary in relation to the varying competence of people and the varying subject matter. That is why I do not see how it can go in the controlled acts list. Nevertheless, in a distinct clause, it would be in the spirit of the Schwartz approach to identify something that is potentially dangerous, describe it without reference to the practice of medicine and then prohibit it.

I invite you now to look to page 3. Some of you are already. I will just look this over with you, the draft wording that begins:

"No person who is obviously not competent to make a particular diagnosis or assessment of a human health condition shall communicate the particular diagnosis or assessment to an individual or his or her personal representative in circumstances in which it is reasonably foreseeable that the person so diagnosed or assessed will risk significant harm by relying solely on the diagnosis or assessment."

Then there are two subclauses, both of which I think are necessary, something like this:

"Where a person is a member of a college, the inclusion of such a diagnosis or assessment within the scope of practice for that college is evidence of competence.

"Where a person is not a member of a college, training or experience"—that is important—"relevant to making such a diagnosis or assessment can be evidence of competence."

The effect on unregulated practitioners would be to make them be cautious about communicating a diagnosis or assessment in very circumscribed circumstances. One doubts whether the matter is within one's competence to judge whether if the client relies solely on what one says it could result in significant harm. So it is not that every time you open your mouth you are going to be worrying about being dragged into court. It is circumscribed.

It would be difficult for a court to prove obvious incompetence, except where a practitioner lacks the special technical-scientific training which is obviously needed in some cases—obviously to any rational person, a judge or a juror. Telling someone he is depressed requires no such training. It seems unlikely that the clause would impose a burden of undue caution on responsible unregulated workers.

Concerns about one's competence and about risk of significant harm would only arise when one might make an authoritative communication. This does not cover treatment. Some of you would see this as a disadvantage. But that would get us right into the issues around the harm clause: that everything you did or said, you would have to be weighing whether you could be hauled into court. No, this is very narrow, very specified. Here, the clause would encourage unregulated workers in some cases to recommend that the client consult someone more competent in the area. That would be a good defence, in other words, if you are in doubt. You would say, "You had better see somebody else; this is what I think it is." This could often be a medical doctor, and in my own view it often would. That is where someone would obviously be sent. But it could be someone in one of the other professions—say an audiologist; it is a preliminary meeting about hearing—or it might be another unregulated practitioner, depending on what kind of problem the client has.

So the idea that there are different kinds of expertise relative to the kind of communication is crucial here. The clause would provide a deterrent to charlatans who have not the foggiest notion concerning the health condition which they are claiming to identify definitively. The clause would put into law, I think, what any responsible unregulated practitioner would do in any case.

A few comments on this. You will see them later on elaborated. The word "obviously" is important, although I realize that in law they do not like adverbs like this. "Clearly" or "grossly" incompetent—maybe we cannot do it that way. It is important for two reasons: so that the courts do not get into subtle issues of determining competence. That is not the place of the courts. Also, to put the onus on the court, where a person has to rely on experience, it is hard to prove that you have the experience. It is not so hard to prove that you have taken such-and-such a technical-scientific training. So the reference to experience is crucial.

In the field of mental health, psychotherapists often think that the main way to become a psychotherapist—not the only part—is to undergo psychotherapy. It is a matter of experience. Then counsellors at the stress centres, who often have a better track record than the professionals there, I am told, simply have experience. It is not primarily training at all.

We put in both "diagnosis" and "assessment" so that the court does not get bogged down in trying to decide whether this is a diagnosis. Put in both words; it covers the field.

Finally, I would just like to comment that the regulated—and this is not in the report—could perhaps add something like the clause in relation to the unregulated so that individuals—say, an individual nurse, just to take one example—who have had special training beyond the scope of practice as listed could give an assessment, or even perhaps call it a diagnosis, a nursing diagnosis, beyond the scope if they have had specific training.

1020

I have heard that both nurses and social workers are in the business of diagnosing in the psychiatric realm. There are just not enough psychiatrists to handle all the admissions now. This may be shocking, but this would legalize what is actually going on—shocking in that it apparently would probably violate the law, but this would be an incentive for people to take special technical-scientific training, whether they are regulated or unregulated.

I have only left one minute—a couple a minutes, I guess; we started late.

The Chair: Thank you very much for your presentation. We have one minute.

Mr Owens: The question around the issue of competency—I am just wondering why the onus should not be on the professional to demonstrate competence. The language around the person who was obviously not competent I find problematic. Even the Occupational Health and Safety Act has gone to great pains to identify what is competent. Do you have a comment on that?

Mr Evans: From the point of view of the practitioner it is important that whenever they are saying something in the course of treatment they are not having to worry about whether this is on the border, and this is very important, I think. Also, the point to the law, as I see it, is not to be able to nab everybody who has gone a little bit beyond his competence in saying something, but to try to nab the charlatans, the sharks, the extreme cases. That is the reason, as I see it, for that kind of emphasis.

It is possible that the other parts of this proposal, relying solely on what was said and the risk of significant harm, would protect the practitioners sufficiently. I grant you your point that in other areas it is just competency; it is not obviously competent.

The Chair: Thank you very much for your presentation. The committee appreciates you appearing before us. We have received much correspondence from you and would encourage you, as the course of these hearings continue, if there is information that you think would be helpful to the committee, to please continue to communicate with us in writing.

Mr Evans: Thank you.

The Chair: Thank you very much.

ONTARIO ASSOCIATION OF PROFESSIONAL
SOCIAL WORKERS

The Chair: I would like to call now on the Ontario Association of Professional Social Workers. Please come forward. You have 20 minutes for your presentation. We

would ask that you begin by introducing yourselves to the committee, and we would hope that at the end of your presentation you would leave a few minutes for questions from committee members. Please begin your presentation now, and welcome to the standing committee.

Mr Levine: Thank you very much for this opportunity. My name is Leonard Levine, and what I plan to do is provide a few introductory remarks and then call upon two of my colleagues to supplement, through their personal experiences, some of the issues we are concerned with.

I should mention at the outset, if people want to know more about us, on page 11 of our brief there is more amplified information about each of us.

What we hope to do is to cover our presentation in some 10 to 11 minutes, and then hopefully there will be some questions we can then respond to, if we are able to.

I should mention at the outset that we are here in support of the legislation you are engaged upon, and we recognize the difficulties and challenges that are before this committee. Many briefs will be presented to you in the course of these next few weeks. Having said that, however, we are also here to add to your concerns, because we have some major reservations about some of the things that are still remaining in the legislation.

First of all, we do applaud the removal of the so-called harm clause and urge you to maintain its omission from the final document, because that did cause us, as many other people, a great deal of concern, so we applaud your latest revision on that basis, but again, we stress that we really feel it is very important to ensure that is permanently removed.

Our major concern remains—at least one of them—around the area of the diagnosis clause, which is referred to in paragraph 26(2)1. There, too, like our previous colleagues, we feel that the difficulty of eliciting what diagnosis is in a health setting is extremely complicated and would interfere with the rightful jurisdiction of social workers, both within and outside of health settings.

We also cannot accept the distinction that has been made between diagnosis and assessment, and we would certainly welcome if that could be clarified, because we found we were not able to distinguish that, although we have been assured that assessment is okay where diagnosis is not. We are not concerned about that because it provides us with the hazards that are known.

As a recognized profession that has been in existence since 1964, as a recognized group that has extensive training programs within this province, we really feel that we have a scope and a legitimacy of practice that needs to be maintained rather than put in some jeopardy, as we submit this legislation may provide.

Certainly, having been involved in education in the health field for some 25 years, I can attest to some of dilemmas that we know are before you. A previous colleague has mentioned the situation in mental health. We can extend that to areas like rehabilitation, primary care, addictions, gerontology, where the definition of "health" can be so broad as to embrace any practitioner as well as a parent, or can be so narrow that it does not reflect the reality, and we understand this is the thin line that is being trod in terms of this legislation.

In the diagnosis clause, where areas like disorder and dysfunction are mentioned, we feel these are not necessarily restricted to health professions, but we as a profession have long been involved with the psychosocial diagnosis, assessment and indeed treatment of people who present to us with problems.

My two colleagues will be dealing with the situation of social workers in the health setting—that would be Mr Paul Soren—and Ms Miriam Mayhew will be dealing with social work outside the immediate health setting, but areas the legislation cause some problems with.

Again, we would like to applaud the recommendation of having advisory councils and, as a profession, we certainly support the involvement of consumers extensively and certainly would offer every collaboration we could provide in that pursuit, as indeed in any further explorations that this legislation may encounter.

Without further ado, I call on Mr Soren, who will talk about work within a health setting and the dilemma this legislation is suggesting.

Mr Soren: My point really is that the practice of social work in a hospital setting, in an acute care hospital setting in particular, is going to be constrained by the diagnosis clause. Having said that, I would like to share a little bit with you about the practice of social work in hospital settings.

The role of the hospital social worker is to promote adjustment by the patient and family to his illness. We attempt to consider effective ways of responding to the social factors and problems we see as they contribute to the health needs of the patient or consumer. "Consumer" I use in the sense that the consumer has choice. From time to time my language will include the word "client." "Client" may be a situation where a person is seeing a social worker not necessarily because he wants to.

Social workers focus on assessing post-hospital care needs and having a discharge plan ready to implement the moment a patient no longer requires acute inpatient care. Social workers' direct patient care responsibilities include discharge planning, individual, group and family therapy and co-ordination of care. In most hospitals social workers have educational qualifications of a BSW degree, most frequently an MSW degree and, in some cases, training at the doctoral level. Membership in the Ontario Association of Professional Social Workers and the Ontario College of Certified Social Workers, though not required, is encouraged.

Social work is an essential service in light of the purpose and goals of the acute care hospital. Our values we bring, our contribution to conceptualizing issues, our contribution in relating the hospital to the community are important.

Dr J. A. Brown, a social worker who directs the department of social work at Chedoke-McMaster Hospitals in Hamilton, has annotated in *A Justification of Social Work in Health Care Settings* that in acute hospital populations 40% to 50% of patients have psychosocial problems, and the prevalence is thought to be greater among chronic and rehabilitation patient groups. Literature is available to indicate that poor adjustment to illness has been associated with life stress, social isolation, unfavourable self-concepts, poor social relationships and negative attitudes.

1030

Social workers in hospital settings frequently communicate and interpret information about diagnosis to consumers and their families. On page 2 of your brief is a very good illustration which I will read with you, if you would like, about a scenario that involves a person who has been diagnosed by a physician as having a life-threatening illness such as cancer. This person may receive professional help from a social worker who is part of the health team or be referred to an independent social work practitioner. The social worker would discuss the implications of the diagnosis, assess the emotional response, assist the patient and the family in exploring realistic options for dealing with the effects of the illness and provide therapeutic counselling to help the patient maintain an appropriate degree of self-reliance through the period of adjustment. The social work assessment could be used by other members of the health team to assist them in the further treatment of the patient, including advising team members of cultural, economic, social and psychological factors which need to be considered in providing treatment.

A different scenario could involve working with a person who has been diagnosed as having a mental illness, such as schizophrenia. The person may receive professional help from a social worker who completes a psychosocial diagnosis and/or comes to conclusions about the impact of the illness. This assessment of a person's dysfunction is particularly important, because the literature highlights the importance of examining social relationships and events such as post-discharge environment, focused social skills and housing status as predictors of rehospitalization. The information is thus useful in formulating a plan for the provision of treatment services. In effect, communicating a diagnostic formulation or conclusion constitutes an essential component of the social worker's intervention.

In light of the high prevalence of psychosocial disorder among hospitalized populations, the strong relationship between this psychosocial disorder and the patient's attitude, or poor social support, including family dysfunction, and finally, the relationship between poor adjustment to illness and the cost of using health services, there is a growing need to continue providing targeted social work services to those high-risk and costly populations who use all health services.

The professional social worker in the acute care hospital is concerned with the social, physical and psychological wellbeing of the client. This includes concern for the client's family, care givers, consumer survivors, staff and community.

Issues in relation to the meaning and interpretation of key operational terms, such as "communicating a conclusion," "disease," "disorder," dysfunction," as appear in the diagnosis clause, paragraph 26(2) in Bill 43, are of major concern to social workers in hospital settings. It is important that the legitimate work for which professional social workers are trained, for example, psychosocial assessment, communicating and interpreting information, is not necessarily constraining and restrictive.

I thank you for your attention; I will pass on to Miriam Mayhew.

Mr Levine: Ms Mayhew, along with dealing with some general concerns, will also be drawing attention to

another clause that causes concern, particularly with people in other fields.

Ms Mayhew: The Ontario Association of Family Service Agencies is a provincial umbrella association for 47 family service agencies around the province. We are glad of this opportunity to meet with you and to support the work of the Ontario Association of Professional Social Workers in drawing your attention to some of the concerns that we have about Bill 43. It is an opportunity for us to demonstrate to you that the meaning of the term "health" extends actually far beyond those settings which are clearly and obviously health settings or medical settings.

Family service agencies offer a very wide variety of services to their communities. These services include counselling to individuals, couples, groups and families where there are emotional and familial problems. Many clients served by the agencies are dealing with the psychological and emotional sequela of childhood trauma, including physical abuse and incest. Many more have difficulties in interpersonal functioning which lead to problems in their ability to maintain relationships at home and at work. Still others are trapped in a deepening cycle of poverty and hopelessness and require intervention which will allow them to cope and hopefully to make what changes are realistic. Many clients are struggling with problems related to substance abuse, and there is a sizeable group of clients who are chronically psychiatrically disabled and who are unable to receive treatment in the health system beyond that of the prescription of medication. A large and growing proportion of our clients, those served by family service agencies, are involved in families where there is violence. Family service agencies provide service to the victims, perpetrators and witnesses of this violence.

The staff in family service agencies are almost without exception members of professions which are not listed in schedule 1. They are mainly social workers. These staff are trained to perform psychosocial assessments, to share with their clients the conclusions of these assessments and to arrive at an understanding of the goals which both client and consumer will seek to meet. This is a professional process which demands that its practitioners be qualified and accountable.

Family service agencies are solidly in support of Bill 43's attempts to provide for the full accountability of professionals. They find it incomprehensible that the legislation does not include social workers as a regulated profession, and because of the profession's exclusion from the proposed legislation, perceive a serious threat to the legitimate practice of their profession.

The Ontario Association of Family Service Agencies and the Ontario Association of Professional Social Workers are both on record as supporting the drive to secure a social work act in Ontario through the Ministry of Community and Social Services, and we note that this is the course that the drafters of this piece of legislation advised us to follow.

Bill 43 does not restrict its definition of "diagnosis" to medical diagnosis. Accordingly, family service agencies fear that the psychosocial assessments performed by its staff may be considered to be controlled acts. They have

heard the verbal reassurances that this is not the intention of the legislators, but we are not reassured.

Subsections 38(1) and (2) of Bill 43 outline that employers and boards of directors are at considerable risk of prosecution should staff perform the controlled act outlined in subsection 26(1). Since we have no substantive reason to believe that social workers are not placed in jeopardy by this section, we must conclude that the practice of social work, the employment of social workers and the governance of social work agencies are activities directly threatened by Bill 43 as it is presently written.

The Chair: Thank you for your presentation. I have some questioners, if you have finished your presentation.

Mr Jackson: Perhaps I will start with the very last statement that Ms Mayhew made with respect to their interpretation of the implications of, I think she referenced section 38. Perhaps we could ask legal counsel if they concur with that opinion that we have placed social workers and social work professional activities in that context through this legislation.

Mr Levine: Our legal advice—

Mr Jackson: I have asked legal counsel, and then I might come back to you, if the chairman will permit me, but I would like you to hear their response first.

The Chair: I am going to direct that question to the parliamentary assistant.

Mr Wessenger: I will refer that to counsel.

Ms Bohnen: The government's view is that social work diagnosis, or as we have heard this morning, psychosocial assessment, would not be affected, would not be restricted by this legislation, and that therefore employers of social workers who perform psychosocial assessments or diagnoses would not incur any potential liability.

Mr Jackson: Can you direct us to a specific statement in the legislation, a specific clause, which is a safe harmless clause for them in the context of what you just said?

Ms Bohnen: No. There is no clause saving them harmless.

Mr Jackson: Then what clause states what you just said?

Ms Bohnen: The government's view is that the controlled act in paragraph 26(2)1 does not capture social work diagnosis.

Mr Jackson: Can we say that specifically, that they are exempt and outside? Is that how we are doing it?

Ms Bohnen: The government's interpretation of the clause is just what I have said to you.

The Chair: Mr Jackson, there are other questioners.

Mr Jackson: If you are cutting me off, perhaps we could let the deputants respond to the information we have just heard.

The Chair: All right. Would you like to make a comment?

Mr Levine: Just a brief statement. Although we applaud the intention, our legal advice says it still would have what is called a chilling effect on social work practice because it is not exempted.

1040

Mr Jackson: Could we get a copy of that as a point of information?

Mr Levine: That is included in our brief.

Mr Ruprecht: Just briefly, looking at your recommendations, other than your recommendation to persuade the Legislature, as you have done previously, to create a social work act, are you essentially in agreement with the coalition that the diagnosis clause, as you have described it here, is essentially similar to what they have presented to this committee?

Mr Levine: Yes, indeed. We certainly do support their concerns as well in reference to the diagnosis clause.

Mr Beer: With respect to the question around regulation—I just want to be clear for the record—your preference would be to have a social work act and to be regulated under such an act, or would your preference be to come within the scope of this act?

Mr Levine: As a profession, we have followed the advice originally of the Health Professions Legislation Review that we pursue our social work act within the Ministry of Community and Social Services, because not all members are related to health settings, and that is the reason we are pursuing this at this time.

Ms Mayhew: I think we need to make the point fairly clear that, while we very much want a social work act in Ontario, the achievement of such an act will not solve some of the problems that we have identified in this bill.

Mr Beer: That was my second question, to determine that even with that you would still see difficulties.

Ms Mayhew: Yes.

Mr Jackson: And we are the last province in Canada not to have one.

Mr Levine: Yes, exactly.

The Chair: Thank you very much for your presentation. We appreciate you coming before us today.

THREE TRILLIUMS COMMUNITY PLACE

The Chair: I call next Three Trilliums Community Place. I would like to welcome you before the standing committee on social development. You have 20 minutes for your presentation. We would ask that you introduce yourselves to the committee and leave a few minutes for questions from members following your presentation, if you would. Please begin now.

Ms Isabella: Last week, Victor Willi of the Centre for Independent Living in Toronto spoke to this committee about independent living for persons with physical disabilities. He referred to the struggle by people with disabilities to have the right to live in the community as "the last civil rights movement." Mr Willi also explained why self-directed attendant services are such an important element in this struggle for independence.

I am speaking to you today as a representative of one of the many organizations which provide attendant services to adults with physical disabilities. Three Trilliums Community Place is a non-profit organization wholly funded by the Ministry of Health and the Ministry of Community and Social

Services. With the assistance of our attendant staff, Three Trilliums' clients are able to live in their own apartments, go to school, work, pay taxes and vote; in short, live independently. I am both the chairperson of Three Trilliums' board of directors and a consumer of Three Trilliums' services.

In the course of the last year, our board has written to successive ministers of Health to express our concern with some of the recommendations of the Health Professions Legislation Review. The recommendations which caused us concern have now become part of Bill 43.

Paragraph 26(2)6 of Bill 43 would include as controlled acts some of the bowel, bladder and other personal services which we consider to be non-medical. We have been providing these services to our clients on a daily basis since our project opened in 1980. This section would require that some routine functions in the daily lives of people with disabilities be brought under the direction of a health professional.

The ability of our clients to determine the extent and timing of the services they require and to direct our staff in the provision of that care would be subordinated to the control of the governing council of a health profession.

On July 16, 1990, we were advised in a letter from the then minister responsible for disabled persons that "an appropriate exemption will be created—through regulation—removing the activities of personal care attendants from the controlled acts."

In the face of fines of up to \$25,000 for performing the controlled acts, Three Trilliums is not satisfied that its concerns will be met by an exemption created through regulation. To our knowledge, the promised regulation has not yet been drafted. Consultation on the terms of such an exemption, we are told, must wait until after the passage of this legislation. Will the exemption be comprehensive? Will it be subject to veto by the health professions? Will it contain additional, as yet unknown, barriers to be crossed?

Three Trilliums supports the view expressed to you last week by Mr Willi. The drafters of this legislation want to regulate the health professions. We have no argument with that, but do not include attendant services in your legislation. Attendant services are not health services requiring regulation. Attendant services must remain subject to the control of those people who rely on them to maintain their independence. People with physical disabilities should not once again have to argue for special measures to protect their right to decide what is best for themselves. They should have the dignity of risk and they should have the choice to live independently.

We would like therefore to repeat our recommendation that Bill 43 be amended before passage to include in section 28 an exception to allow consumers to retain the option of directing their own support services. Such an amendment should be drafted to ensure that the exception applies to the consumer of attendant services and not to the service provider or attendant; to those consumers who require services of a routine and stabilized nature; to those consumers who are capable of directing their own services; and, to all those activities of daily living which an individual would do for themselves if it were not for a physical disability.

Mr Beer: When Victor Willi was here last week he noted there was to be a meeting, I believe, between representatives from the different disabled organizations and the OMA. Part of the discussion was to be around how this might be dealt with. I wonder whether you know or perhaps participated in that meeting. Was your proposal on page 4, where you make the recommendation that we change section 28, which would then allow the attendant care services to be exempted, the proposal that was put before the OMA, or is there anything that you might be able to report back to us on how those discussions are going?

Ms Isabella: There are various organizations in the disabled community that are working on that wording right now, so it is my understanding that there is going to be work done. We are not going to draft the legislation, but give input into the wording that might be acceptable.

Mr Beer: As we said to Victor when he was here, the committee would be very interested in being made aware of the results of the discussions, because I think we are all struggling with a number of issues. I think that this would be shared by all members of the committee; we do not want to limit the development of attendant care services. Indeed, the thrust in many other programs and legislation is to provide for greater independence for those with disabilities. But we are mindful that we have to get the wording right. We would like to keep in close touch with you on how those discussions go with the OMA.

1050

Mr Jones: If I may add, to our knowledge they have come up with a wording that addresses these areas and that will be submitted to this committee fairly soon.

Mr Owens: My question is to the parliamentary assistant. It is around the issue of consultation that is taking place between the attendant care groups and the ministry. Can you perhaps tell us where you are in terms of wording and what level of consultation is going on?

Mr Wessinger: I probably will refer that for more specific information, but certainly the whole matter is under consideration. We have been trying to work out a satisfactory resolution of the matter. The exact wording has not yet been determined.

The Chair: Mr Owens, as you recall there was some discussion of this and ministry staff placed on the record quite a comprehensive explanation. As well, I think all three caucuses signified their support for this accommodation to be made, as it was not an intention, in any way by anyone, to inhibit the attendant care program. I have asked research to make that Hansard available. Hopefully before noon today, a copy will be available for you. If you require any additional information from the ministry, they can add to that, but I think it was quite a comprehensive response.

Mr Jackson: Madam Chair, might I add to your generous offer of additional information that copies be sent to Ms Isabella and Mr Jones so they can share that with their board? They did take the time to present their case and I certainly would like them to have a copy as well.

The Chair: Of the Hansard?

Mr Jackson: Of the Hansard, specifically referencing the points they have raised in their brief.

My question would have been to legal counsel over the difference between regulatory response to the concerns expressed versus inclusion in the legislation a new section 28e. Do we have a sense from the government if there is a willingness to put that in the bill, as Ms Isabella has indicated, or is it to put it in the regulations? Has there been a change in thinking in this area? I would like the government to clarify, but certainly we have no difficulty in the Conservative Party for having it included in the legislation in the section I have just suggested.

The Chair: On your first point regarding the Hansard, this was discussed at the subcommittee and agreed that the Hansard would be made available to deputants that addressed this issue before the committee. I was pointing out to the committee that we expect to have that Hansard available today. The witnesses that are appearing before the committee will be given a copy of that Hansard. Mr Wessenger, on the second point?

Mr Wessenger: I think we have to go through the hearings process. I assume that, in the normal course of any committee, there will be clauses brought forward for amendments to deal with specific problems before the committee can make that decision of how it is dealt with. I think it is premature until we have completed the full hearings.

The Chair: Thank you very much for your representations and presentation. That Hansard should be here within the next 10 or 15 minutes. We would be happy to give you a copy of that.

CANADIAN JEWISH CONGRESS

The Chair: I would like to call next the Canadian Jewish Congress. I would ask that you come forward and take your place before the committee. We would ask that you introduce yourselves first. You have 20 minutes for your presentation and we would ask also that you leave some time so that members of the committee can ask you questions.

Mr Lenkinski: My name is Louis Lenkinski. I am the chairman of the subcommittee dealing with this matter. With me is Rabbi Sheldon Steinberg, who is the director of chaplaincy; Teri Kay, who is the director of family and community services of the Jewish Family and Child Service; Mr Elliott Karman, who is a clinical social worker; Dr Edmond Lipsitz, who is the director of education and all its services for the Canadian Jewish Congress. I think the best thing would be if I read the submission, and then answer any questions.

We are the Canadian Jewish Congress representing the network of Jewish communal services in Ontario. In our network we provide social work counselling, chaplaincy services to inmates in institutions, vocational and career guidance counselling.

We and our constituent organization wish to express our appreciation to the government of Ontario for introducing the Regulated Health Professions Act, 1991, and its companion Bills 43-64 for passage by the Legislative Assembly of Ontario, in an attempt to regulate the health

professions and to weed out undesirable individuals who take advantage of the most vulnerable members of society.

At the same time, we wish to call the committee's attention to paragraph 26(2)1 of the proposed act, ie, the diagnosis clause, which describes a controlled act as follows: "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion."

In our opinion, the inclusion of this paragraph in the proposed new act would create hardships and conditions under which members of legitimate and necessary health professions would find it difficult, if not impossible, to operate. We strongly believe that it would be inappropriate for paragraph 26(2)1 to remain in the Regulated Health Professions Act, 1991, in its current form, and that its inclusion would expose professional social workers, the clergy, and guidance counsellors to unnecessary risk in their professional practices.

The legislation, as it is presently written, will have a chilling effect in that it may well mean that people in the above stated professions will be unable to give quality counselling or assistance to those who are in need. This would appear to run contrary to the intent of the legislation, and the basic principles of care for those in need of treatment or advice. In light of the above, therefore, we strongly urge the government to reconsider the inclusion of paragraph 26(2)1 in its present form in the the Regulated Health Professions Act, 1991. Respectfully submitted by the Canadian Jewish Congress.

Mr Beer: Again, as with a number of organizations you have put the finger on 26(2)1. I think all members of the committee are going to be traumatized with those numbers and that designation. The problem, as I see it, and I say this partly as a former minister in the former government, and having been in Community and Social Services, and as a non-lawyer, is that we are trying to balance two things: protection of the public and yet allowing professionals to carry out their legitimate responsibilities.

The former government's view and the present government's view is that this paragraph does not cover the work of social workers, that they do not fall under the purview of this. So we are then left with trying to sort out as individual members of the committee, how we change this so that it will both protect the interests that you and others speak to, as well as ensuring that there are not a lot of folks running around giving out diagnoses who should not be doing that.

In the course of your work, as you have looked at this, have you either tried to come up with some wording, or are you aware of what the Coalition of Unregulated Practitioners has come forward with, and also the Ontario Association of Professional Social Workers? Are there some options here that you would like the committee to consider as a way of replacing this specific wording? Because that is our goal here.

Mr Lenkinski: Our position is a very simple one. We are pleading with you to put in a statutory exemption to exempt these groups of which we are speaking from that provision. Our experience with trying to interpret the intent of legislation before the courts is not the best.

I have enough experience in my work in my other capacity. I am a commissioner with the Ontario Human Rights Commission, and I dare to admit it in front of the legislative members. However, I want to tell you that the courts do not interpret your intent properly, because there is a very basic difference between social policy and the law. Do not stop us from providing one of the most vital services to our community, both in the way the clergy and social workers are providing that service, and also how we guide our youngsters in our school system.

Mr Beer: Your sense is that it would be through the route of exemption rather than trying to recast this clause or to draft some other article that would still be the subject of some kind of court interpretation?

Mr Lenkinski: Unless there is, of course, language that would not cast such a tight net to catch fish you really do not want to catch.

Mr J. Wilson: My question has been answered; the response was "statutory exemption," and I will certainly take that into consideration. A number of groups, of course, have suggested that to us. We would be pleased if in the future you could get around to some suggested wording on how that statutory exemption might be helpful.

Mr Lenkinski: Let me add to that. Quite a number of the employees are in the system of delivery of these services as well, and I am suggesting that it would be very presumptuous on the part of our organization to suggest legislative language to you. You have staff, you have lawyers, you have enough people who can come up with very good language to produce the results you want.

Mr J. Wilson: I appreciate that. It is just that if you are lying awake at night thinking about this and you come up with any language, we would be happy to hear about it, because this is a product of staff as it is written now.

Mr Jackson: This is a creature of the bureaucracy you are referring to.

Mr J. Wilson: And they are doing a good job, I might add.

Mr Jackson: Yes, absolutely.

The Chair: Thank you very much for your presentation. If, in the course of these hearings, there is anything further that you would like to communicate with the committee, please feel free at any time to submit briefs in writing or letters via the clerk of the committee. We would be happy to hear anything further that you wish to share with the committee.

Mr Ruprecht: I was somewhat disappointed that Mr Lipsitz, whom I consider one of the wisest men in council, did not say anything.

Mr Lipsitz: It is not wise. My chairman is doing the job.

Mr Ruprecht: He is doing a good job, right?

The Chair: The committee will recess and reconvene at 11:20.

The committee recessed at 1104.

1120

COALITION OF CHURCHES

The Chair: The standing committee is now in session. I would like to call the next presenters, the coalition of major Christian denominations. You have 20 minutes for your presentation. I would ask that you introduce yourselves to the committee and if you will, leave a few minutes at the end for questions from committee members.

Father Cuyler: Madam Chairman, on behalf of the Coalition of Churches, and you can see them listed there, we are here to reaffirm our concern re the wording and implications inherent in paragraph 26(2)1 of the proposed Regulated Health Professions Act, 1991, known as Bill 43.

The present wording of this section does not differentiate between an assessment made by a regulated or an unregulated health care practitioner. This leaves the door open for disgruntled people, not the government, to prosecute any unregulated worker, because they are not excluded and/or identified with this diagnosis clause. Across the province, and within our networks, clergy, pastoral care workers, religious orders, all those listed, this has caused tremendous concern about the effects of this legislation on their work.

None of the unregulated groups or individuals, paid or unpaid, wants to become a test case either. All those listed are called upon in various ways to give assessments and diagnoses by those who look to them for assistance and direction. All of them do far more than talk to people. We have been in communication with the religious community across the province and they have been getting letters back saying: "Oh, it's not meant to affect the clergy. They can continue to talk to their people." Clergy and lay volunteers do a lot more than just talk. In fact, they do the major amount of counselling in our community.

Therefore, if passed, this section would place in legal jeopardy all unregulated mental health workers, regardless of their qualifications and/or training. Whenever they are asked such questions as, "What's wrong with me?" if they respond, "You're tormented by guilt," or "You're very depressed," or "You're an alcoholic," or "Your family is dysfunctional in these ways," etc, then they have just identified a disorder or a dysfunction.

The present regulated health care workers cannot possibly address all the social and psychological needs of the people of this province. That is why there are hundreds of church and voluntary agencies providing a wide variety of services to people who are suffering from a multiplicity of disorders and dysfunctions that are prevalent in our society.

The financial implications of this bill are terrifying. None of the present work could continue without placing its workers in jeopardy unless it was approved by one of the regulated professions. The potential cost to the Ontario health care program would be astronomical and would bankrupt the system within a few years.

We are concerned also about its effect upon the court system, which is already overburdened. Through our present involvement, we are aware that there are thousands of

unstable people in this province who are currently being serviced by our network. If this law is passed, it is clear that those persons who have the "let's sue" mentality will use it. This group of people is all too willing to use a new piece of legislation to get at those who have sought to help. There are also those who, because of their anger or their turf wars or their ideological disputes with the unregulated, can have a field day with this clause.

The Ministry of Health and its staff have continued to say that the diagnosis clause will not cause problems for the unregulated; that the regulated, be they religious or otherwise, may still continue to "talk to their clients." But far more than that is carried out by the unregulated services and their staffs across this province. The Coalition of Churches recognizes that the Health ministry, in drafting this legislation, did not intend it to affect clergy. We are not here just to protect clergy. We are very concerned about that whole network of community services which the religious community provides in a wide range, as well as those provided by a large group of secular agencies across this province. They are all put in jeopardy by this act.

If we are not to be affected, then why were we not involved in discussions in the drafting of this legislation? It is a real concern to us and that is why our members are concerned. Why did the government not consult with the churches, the clergy, the workers, the chaplains in health care institutions, etc? None of our workers wishes to be involved as a test case, standing in a court of law and saying to the judge, "But, Your Honour, this legislation was not intended to affect me."

On page 2 we have put forward some possible solutions. They have been put together by a wide group of people. They are not the sole property of the religious community. We could restrict the unregulated and regulated in different ways. What is the real intention of this piece of legislation in regard to the unregulated? There is a real lack of clarity. One could retain the prohibition of practising medicine without a licence in relation to all the unregulated. You can modify that prohibition in relation to non-medical regulated professions by saying that it only applies if they perform a medically authorized controlled act for which they are not authorized; or delete the first controlled act, relying on the current prohibition of practising medicine without a licence in the case of the unregulated, and introduce a new clause for all the regulated, permitting them to communicate assessments within their scope of practice, as noted in the legislation.

You could restrict the medical diagnosis to doctors and that is another alternative. You could prohibit misrepresentation. Especially where one is communicating an assessment, one must not wrongfully claim to be a member of a regulated profession. Only a member could claim the title of whatever that regulated profession was, and if you are not one, and you are in the unregulated, then you have no right to use it.

Some regulated professions believe that this adequately protects the public. Others would try to find a wording which would also prohibit misrepresentation concerning one's competence to make and communicate the assessment which one has made.

1130

The other one, at the bottom of the page, is that the advisory council should screen prosecutions based on this piece of legislation. Both regulated and unregulated health care workers have reason to fear that, regardless of how various clauses, such as the diagnosis clause or its replacements, are worded, they might be prosecuted because of a turf battle or an ideological dispute.

The coalition recommends that the advisory council's duties should include the screening of all prosecutions under the RHPA except those initiated by a college in relation to its own members, setting aside those which do not pertain to the protection of the public. Since no past or present member of a college can be on the council, there is a reasonable hope that the council will be non-partisan concerning issues of turf or ideology.

Finally, would not the simplest solution of all—we are not legal people; at least we try not to be too legal in our religious networks—be to have a clause that states that the controlled acts concerning diagnosis apply only to those regulated? We do not feel it is appropriate for us to solve this problem or to write what should be there. The suggestions we place before you are endorsed by the Coalition of Churches but have been arrived at in conjunction with a much wider network of concerned people. It is our hope that the religious community will not be overlooked in the future when legislation affecting its work is being drafted.

May we take this opportunity to thank you, Madam Chairman, and your committee for allowing us time on your busy agenda. We hope the suggestions we have brought will be of assistance to you and that the very genuine concerns of the religious community across this province, its staff and all our volunteers who provide such a wide range of important services will be heard.

Mr Beer: Thank you very much for your presentation and for a number of your suggestions. We have had a number of submissions this morning on this specific area. I would like, if I might, to play the devil's advocate here. What I want to get a better understanding of is this: Certainly it was not, I believe, the intention of this government or the previous government or the committee members to ensure that clergy, social workers and various others cannot do a lot of the things they are doing. Indeed, those are worth while and important.

What I am trying to understand in the balance in looking at that clause is, if I were a social worker or a member of the clergy and I were sitting with somebody, counselling that individual and saying—and let's use the examples here—"Look, you're depressed," or "You're having a problem with drinking," whatever, how does that then become, in effect, a case? How do you become limited? As a lay person, I would not think, by any stretch of the imagination in terms of health services, that you are providing a diagnosis or even an assessment. I am wrestling with this. If there is indeed a problem here, how do we cope with that? Perhaps if we could have a better understanding of what it is that is feared will happen or how that will happen, that would help.

Father Lombardi: You are counselling and a married couple comes to you and one has a problem and is brought

on by the initiation of the other partner: "My spouse has a real problem. We should talk. We have a marriage problem." You find out that the person is distraught, and that is shared by one, and the person does not believe that to happen. The argument is between the couple. Then whatever the suggestion of the clergy or the pastoral worker or the unregulated is becomes the issue for that couple. It can result in a lot of problems, one denying, "Well, that's what they said, and you do not want to listen to them," or whatever. I think there are some problems there, and it could result in some further actions, based on whatever is said to that couple, if one refuses to read the writing on the wall either in the marriage or some problem signs. That is a possibility.

Father Cuyler: Could I just respond to that too? It is the wording of the present legislation that when one does that, we have just given a diagnosis, we have diagnosed a dysfunction. That is a problem.

The other is that often, for example, you could have a couple—and both of ours are here, so we could use this one. A girl becomes pregnant, for whatever reason. She could go to one church, because of one parent being of that faith, and could be counselled to have an abortion. The parent on the other side could say, "Absolutely not," and you could get into a major kerfuffle. You get into some of these areas. It is that whole "Let's sue" mentality that is in our world. That is the frightening thing, how people will use any piece of legislation in terms of getting at those whom they feel strongly about. I know Massey and I joked about this in the early stages of it, so I can use that illustration, but it goes way beyond that. It concerns us greatly how that would affect, over the longer period of time, that whole raft of unregulated work that is going on in terms of this problem.

Father Lombardi: Just from personal experience, there are certain areas in professional relationships as clergy people and pastoral workers that clients or people of our faith would readily share with us and not with their medical doctor or with anybody else. I can assure you that is always the case in prisons where I have worked, either with men on death row or other areas. It seems to me there is an area there both of confidentiality and also very personal things that they feel a confidence in. Therefore, in trying to help that person through real pastoral care and spiritual counselling, it requires some diagnosis, either from a moral/ethical perspective or church teaching and everything else. It is those kinds of things that this legislation would threaten.

I am quite certain that is not the government's intention, because if it were—and I am saying it is not—it would negate any of the church-related organizations that have worked closely with government, not to mention the government chaplaincy services of Ontario, where there is a partnership. The government has traditionally viewed the contribution of faith communities and their volunteers as performing a service that no other body can perform, because it is another level. It is that kind of level that is between the lines here. Although it is not the intention of the law—it is not so much between the lines—there are big gaps there. I think that is where the concern is. The vagueness would result, I think, in some very negative

results on how faith communities and their workers can get at what professionals cannot get at in many ways.

Many times in our relationship with people like that, and working in teams in hospitals and chaplaincy, where although it is not confidentiality that is breached, there is a view that is very helpful in the holistic kind of approach in determining what is the matter with this patient and how this ex-offender or offender can be helped to resolve the problems. These are the kinds of things we are concerned about.

Ms Haeck: The previous speaker was just making mention of something I wanted to raise. In speaking with a divinity candidate in my riding, this person put forward the view, and obviously one that many of us also share, that the chaplain working in a hospital setting really is part of a health care team, a feeling that may not always be supported by some in the medical community. But there was definitely this feeling that the whole person needs to be treated and really to be made to feel part of that team. Your basic view is that this is now being compromised by this particular piece of legislation. Would you feel—and I really want a strong confirmation on this one, the yes-no position here—that you would prefer to be clearly exempted, that this does not apply to the clergy, as some other groups have also put forward?

Father Cuyler: I do not think we want it just to apply to the clergy. That is a position we have tried to maintain, why we support the Ontario Association of Professional Social Workers, why we agree with the Coalition of Unregulated Practitioners, and we ourselves have expressed this major concern.

Ms Haeck: So you are really looking for a very clear exemption, of what is included and what is not included.

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Father Cuyler: We want clarity so that people operating within their sphere of competence and expertise and knowledge can function without a cloud over them, always having to be very careful in dealing with the people who look to them for assistance.

Ms Haeck: You raised another point which I would like to address. Obviously you are bringing it here to us today. In the whole consultative process, over the eight-year lifetime of this bill in its various forms, how have you communicated your position in the past?

Father Cuyler: It was not until the legislation was ready for presentation with the Liberal government. We had a meeting. Finally, we wrote a variety of letters and had a meeting with your Chairman. There were, I think, five of us at that meeting. We expressed our serious concerns about this proposed legislation, and since that time we have continued unabated in our opposition to the wording and the dangers inherent in the way it is presently worded.

The Chair: Mr Wilson, you have less than one minute.

Mr J. Wilson: I will ask a less-than-one-minute question, then.

I understand the intent of your suggestion that the advisory council should screen all prosecutions. My concern would be that we would be conferring a quasi-judicial

power to that council that, to this point, is not intended. Can you just expand on what you mean by screening?

Father Cuyler: I think what was in our mind was that rather than every case ending up automatically on the court docket, and you are into the legal process with all the costs and this being criminal legislation, it would go through some process. Whether or not it is this committee, there needs to be some group that would look at proposed prosecution, use of the court system to get at somebody, so that those that were genuine could go on, but those that were purely mischievous would not.

The Chair: Thank you very much. We appreciate your presentation and we hope that as our hearings continue, if you feel that there is anything further you would like to add, you will feel free, as you have in the past, to communicate with the committee in writing.

Father Lombardi: Could I ask a question of the members of the committee? Where does this go from here, as far as you are concerned?

The Chair: The process of the committee hearings is that following the public hearings, probably after the Legislature resumes on September 23, the committee will sit in clause-by-clause discussion of all the pieces of legislation, during which time amendments can be proposed and discussed and then voted on in committee. The bills will then be—the technical term is reported to the Legislature after they have been fully completed in discussion at the committee level. They will be reported back to the Legislature, where they will receive committee of the whole, potentially, or third reading discussion and debate, when it is ordered by the government House leader. That is the legislative process.

Father Lombardi: Will there be any opportunity for any of us, including ourselves, for another review of that, in terms of any wording? How is that going to work?

The Chair: You are welcome to communicate with the committee in writing at any time during the hearings process and, as well, as it continues through the legislative process, to let individual MPPs, the minister or any members know the positions that you hold about the actions or suggestions that have come forward, but this is the only opportunity for you to present during the public hearings. There are many who, given the time available, have been asked to submit briefs in writing. All briefs which are submitted to the committee will be appended and become part of the public record.

I appreciate the committee members giving me the opportunity to explain that to the deputants. I hope you agree with me that it is important that the process be clearly understood.

CONSUMERS' ASSOCIATION OF CANADA (ONTARIO)

The Chair: I am going to call now on the Consumers' Association of Canada, Ontario section. Please begin by introducing yourselves. All the members of the committee have received a copy of your brief. You have 20 minutes for your presentation and we ask that you leave some time,

if you would, for questions from committee members. Thank you very much. Please begin now.

Mrs Rubino: My name is Rose Rubino. I am the health committee chair. With me is Lucienne Bushnell, vice-president of policy and issues, and Beatrix Robinow, the former health chairman and now a member of the health committee.

The Consumers' Association of Canada, an independent, non-profit, voluntary organization, represents and informs consumers and advocates action on their behalf to improve the quality of life. It is the largest organized consumer group in Canada. The Ontario branch of CAC has over 50,000 members. Consumer advocacy, consumer representation and consumer education have been the major activities of CAC and other local associations throughout its 44-year history.

Health and health care are priority issues with CAC. One of our primary concerns is consumer access to high-quality health care at an affordable cost. The Consumers' Association of Canada Policy Statement on Consumers and Health Care, October, 1989, is a detailed document explaining consumer rights and responsibilities concerning health matters.

Our association firmly believes that all consumers have certain basic rights. The International Organization of Consumer Unions' 1984 consumer rights were adopted by CAC (Ontario) in April 1991. They are the right to basic goods and services, the right to safety, the right to be protected, the right to have choices, the right to be heard, the right to redress, the right to be informed and the right to a healthy environment.

CAC is fully committed to the rights of consumers to be informed, respected and to participate in reaching decisions with respect to their health care. The health committee of CAC has been interested and involved in the Health Professions Legislation Review from the beginning and made an extensive submission in January 1985. In May 1989, CAC expressed its concern to the Minister of Health on the implications of the Schwartz report.

We are pleased that the act provides for a uniform regulatory structure across all health professions, a more open and accountable complaints and discipline system with a greater public involvement on college councils and in public hearings, and a clear description of all regulated health professions and the scope of practice of each.

CAC is very disappointed that Bill 43 omits sections 27.04 and 27.05 which were contained in the Health Professions Legislation Review, *Striking A New Balance: A Blueprint for the Regulation of Ontario's Health Professions*. These sections stated:

"27.04 (1) No person shall treat, offer to treat, or advise in respect of any human health condition in circumstances in which the treatment, offer of treatment or advice, or an omission therefrom, has resulted in harm or may result in a risk of harm.

"(2) Subsection (1) does not apply to a person who is a member of a regulated health profession listed in schedule A where the treatment, offer of treatment or advice is part of the practice of the profession of which the person is a member.

"(3) In subsection (1), 'harm' includes (a) any or increased physical or mental disease, disorder, dysfunction, injury or pain and (b) death or earlier death.

"27.05 A person who contravenes section 27.04 is guilty of an offence and on conviction is liable to a fine of not more than \$25,000 or to imprisonment for a term of not more than two years, or to both."

In response to the ministry's request for comments on sections 27.04 and 27.05 of the Health Professions Regulations Act, 1990, the Consumers' Association of Canada on October 4, 1990, forwarded our support for this section and also offered an alternative wording. However, this section has now been deleted from the act. It would appear that criticism of the original wording and concern as to the enforceability of this section was received by the ministry from various sources. Possibly concerns were also raised by unregulated practitioners, such as social workers and clergy, who felt it opened them up to potential prosecution in connection with their counselling activities.

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To CAC it appears that the baby has been thrown out with the bathwater. Section 27.04 was aimed at preventing harm resulting from treatment or advice provided by persons who were not members of regulated health professions or who, if they were, exceeded their scope of practice or licensed acts. Section 27.04 was a vital component of the licensed act scheme and the act's viability has been compromised by its omission.

CAC recommends that sections 27.04 and 27.05 be rewritten and reinserted into the act. This would then ensure that one of the objectives of the act is met, namely, that "the public must be protected from unqualified, incompetent and unfit health care providers to the extent possible."

CAC is greatly concerned about the lack of control of the unregulated professions. We feel that among the unregulated practitioners there may be questionable therapies used which are based on unusual and untried treatment whose safety and/or effectiveness has not been demonstrated. Consumers must be made aware that some harm could come to them when they receive treatment by alternative practitioners, since such treatment may unduly delay needed help from traditional medicine. Also, CAC believes that some of the unregulated practitioners may use false degrees, titles, variations, abbreviations or an equivalent in another language to persuade the public of their training or expertise.

The association therefore recommends that the Ministry of Health undertake a review of alternative health care therapies. CAC (Ontario) further recommends that truth-in-advertising provisions should be enacted to prevent those not regulated by a professional body from misrepresenting their activities to the public through false advertising.

CAC believes that the legal language embodied in Bill 43 and its companion bills will not be readily understood by the lay reader. We would like to make a strong case for the provision of clear, simple guides to the legislation written in plain language. Consumers will also need guidance as to the qualifications and scope of practice of each of the professions involved.

Beyond the present acts, but of equal importance to consumers, would be a list of the training/qualifications of each kind of practitioner as required by each college. Many questions can arise in the minds of consumers, such as; how long does a chiropodist train? What kind of degree does a practical nurse have? What is the difference between an optician, an optometrist and an ophthalmologist? What is an endodontist? Is a nutritionist the same as a dietician, and so on. A glossary of all the terms, restricted or not, would be useful and is definitely recommended. Consumers need to know the definitions of the large variety of practitioners. This could possibly be accomplished through a fact sheet.

Consumers, particularly the disadvantaged, have always faced a challenge in accessing information. How can consumers find out where to contact an audiologist, occupational therapist, psychologist or the affiliated college? Will each college have a listing in the white pages of all telephone directories in Ontario?

A further problem arises. For example, how will consumers know that the appropriate college for a speech therapist or speech-language pathologist is the College of Audiologists and Speech-Language Pathologists of Ontario? In the Toronto telephone directory at present, most of the individual colleges are found under the key word "college." However, most regions outside of the Toronto area lack such listings.

Information regarding the complaints and discipline and appeal process also needs to be available to consumers. The onus for providing this information should be on the appropriate college. A description of the Health Professions Board and its function should be made available to consumers upon request. Information should also be available to consumers about those professions which are not covered by insured health benefits, and under what conditions and limitations, if any. CAC recommends that consideration be given to storing all of the above types of information in a data bank whose contents are readily accessible to the public.

CAC is concerned that sufficient thought may not have been given to the expanded use of the title "doctor." We believe that this expanded usage—i.e., use of the title by chiropractors and so on—will result in confusion to the public. We wonder what process was used to decide on this expanded usage. What factors were considered? Who was consulted, and which groups favour the expanded usage?

Our association is also disturbed about the use of restricted titles. In each case the title is restricted "in the course of providing health care to individuals."

Many of the professional groups to be regulated provide services to consumers in areas which may not be considered health care, yet are within their scopes of practice, i.e., physiotherapists, occupational therapists, psychologists and speech-language pathologists who work in school settings and provide educational support not related to health status. Business, industry and government also use occupational therapists, audiologists and psychologists to provide evaluation and consultation with regard to work performance, organizational issues, quality of working life and vocational career planning. We are concerned that unregulated practitioners will be allowed to use protected titles in the provision of services which are not considered to be health care.

CAC believes that the Regulated Health Professions Act should protect health professionals whatever their work setting. The appropriate section could read: "No person other than a member shall use the title _____, a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide services in Ontario." In a similar manner, each appropriate section could be altered to contain a statement to deter unqualified individuals from intentionally misleading the public, as recommended in the preface of the Health Professions Legislation Review.

The very narrow scope of the actual restricted titles is a cause for concern. One may not call oneself a psychologist or a nurse but can still offer psychological services or nursing services. One can even claim to give medical services. The question arises as to whether restricted titles are too precise. Physiotherapists feel that "physical therapist" should also be restricted. Other titles which might reasonably be restricted are "nutritionist" and "speech therapist," because these are the terms familiar to consumers. The intent of the section of the act is laudable. However, the resulting practices may not be to the benefit of the consumers of health services. CAC urges a closer look at these sections.

CAC is concerned regarding limitation to certain professions of the "communicating to the individual...a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms." It is unclear as to how much of a departure this is from present practice. We believe that a significant departure from present practice would result in frustration and emotional distress to patients and should be avoided.

Health care providers understand the functioning of the human body in a way that few members of the public do, even those who are health conscious and well educated. At those times when consumers require health care, they often tend to become confused and fearful and are generally very vulnerable. Therefore, an extensive public education process is critically needed. This will ensure that people have the information they need to make informed decisions about their own health care.

A vulnerable consumer seeking health care may not know what questions to ask and may be very intimidated and confused. It must be the duty of the professional health care giver to answer those unasked questions and, ideally, to make written information available to the consumer. Health care providers must be educated to provide the necessary information to consumers as part of their service. The right of the consumer to be informed is particularly important in the area of his or her health. All involved in the system have a special obligation to ensure that consumers receive the necessary information regarding their health care and/or medical procedure.

The act is probably not the place to address this important concern. However, CAC cannot miss the opportunity to make a plea to the ministry to institute a consumer education awareness program in conjunction with the introduction of the Regulated Health Professions Act.

CAC appreciates this opportunity to express our views on this important legislation.

The Chair: Thank you very much for a thoughtful and excellent presentation. We have some questions.

Mr Martin: I also want to thank you for coming forward. It is rather refreshing after we have sat through numerous presentations by groups who represent deliverers of health care to hear again from the consumer. You make some excellent recommendations. It is interesting to see the "harm" clause back on the agenda from your perspective and also the issue of plain language.

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The Chair: Time for a question.

Mr Martin: Yes. You had mentioned in here that it was important for us to be out there listening to the consumer. What is the process you have involved yourselves in to make sure you represent the voice of the consumer when you come to these hearings so we might understand that as well?

Mrs Bushnell: We have about 50,000 members, who are not all active, that is true; however, it is a network. We have eight local associations and a variety of committees. Most of the comments we have made here are based on the national health policy, which then represents a whole lot more consumers, because then it is the national policy.

CAC is three-tiered. We represent the provincial, but there is also the national and the local, so we are sort of in between. We get some grass-roots information and we also get from national. The recommendations we have made are based on these two things, grass-roots information that comes from the locals and also from the national association.

Also, at the Ontario level we have a network of volunteers whom we send questionnaires to. These people are not necessarily CAC members. They are people we have recruited who are willing to answer questions on various issues, and we have had questionnaires about health issues. These are the sources where we get our information.

Mr J. Wilson: Thank you for an excellent presentation. Just to note that earlier on I did ask the staff of the ministry to ensure they inform the committee what their intentions are in the area of a consumer education awareness program. I very much appreciate your point there. Have you been involved to date in any discussions with the ministry concerning such a program in the dissemination of information?

Mrs Rubino: I wonder if this is the time. Yes, we have—

Mr J. Wilson: It is an important aspect of the act. No use having one if no one understands it.

Mrs Rubino: Exactly. Lucienne, do you want to fill them in on our health innovation fund request from the Premier's Council?

Mr J. Wilson: Put a plug in.

Mrs Rubino: So this ties in too.

Mrs Bushnell: Yes, right. This is a little tricky.

Mr J. Wilson: I did not know I was setting you up.

The Chair: I would advise that there are just a few minutes left for questions and you might want to submit that information to the committee in writing.

Mr J. Wilson: Go ahead now.

Mr Jackson: Put it on the record.

Mrs Bushnell: I will do it quickly because we are really at the last minute waiting for the response from them. I hope

the letter may not take too long. We have submitted to the health innovation fund of the Premier's Council a proposal to establish as a pilot project consumer health information. This is a partnership between the library of science of the University of Toronto, the public libraries of Toronto and the consumers' association.

Mrs Rubino: And the Toronto General Hospital.

Mrs Bushnell: Yes. What we are aiming to do is to establish a real database in a public library of information that would be consumer-driven. In other words, the consumer phones, asks the information and the database will be developed according to the type of request we get. This is an 18-month project, and the idea is that it is a test pilot and we want to then expand it to the north, the east and the west and all of Ontario. Right now we are waiting for what we hope will be a favourable response.

Mr Beer: With respect to the restriction of the title "doctor," we have had a number of presentations from individuals who are active in related health care fields, speech therapy for example, where it has been put to us that someone who has received a doctoral degree should, like anyone else who has a doctorate, be allowed to use the title "doctor." We have discussed how to balance that off with the MDs and so on. In coming to the conclusion you have, or at least expressing the concern, how would you handle that? On the one hand, one can understand wanting to know who is the medical doctor, but should this legislation be, in effect, restricting other professionals from using a title which has historically been one that is allowed?

Mrs Rubino: I guess one approach would be if they used the title after the name.

Mr Beer: Like PhD.

Mrs Rubino: Yes, PhD, MD or whatever.

Mr Beer: All right. That is one suggestion. In terms of those who are being allowed to use the actual title "doctor," you raised questions here. Is it that you believe only medical doctors and dentists should be able to use that title? Are you opposed to chiropractors and psychologists using that as well? I know you raised the question, but I want to be clear on it.

Mrs Rubino: I am just raising the question. I am curious as to what the process is. How was the decision made? I would think this decision should be made by academia, government, health professions, consumers. I just do not know how those decisions are made now.

Mr Beer: Fair enough. Thank you.

Mrs Bushnell: I would like to add to this too. I agree with you. Somebody who has a PhD deserves the title "doctor," but I think a doctor of philosophy or a doctor in whatever, it does make them experts on human nutrition, for example. Whereas, if it is presented that this is a doctor, a consumer may misunderstand what it is. I think we have to clarify that, yes. Somebody with a PhD, or a physician, is a doctor and the other one may be a therapist. I think that would be much clearer in the minds of consumers.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today. I would remind you that if in the course of these hearings there is additional information you think would be helpful for the committee members, you can submit it in writing to the clerk at any time. Thank you very much.

The committee recessed at 1207.

AFTERNOON SITTING

The committee resumed at 1401.

ASSAULTED WOMEN'S HELPLINE

The Chair: I would like to call on our afternoon presenters, the Assaulted Women's Helpline. Please come forward and introduce yourself. You have 20 minutes for your presentation. We would ask you to leave a few minutes for members to ask questions.

Ms Kneen: Good afternoon. My name is Cathleen Kneen. I am speaking on behalf of the Assaulted Women's Helpline with reference to Bill 43.

Our major concern is the diagnosis clause, paragraph 26(2)1, which prohibits "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion."

The Assaulted Women's Helpline receives between 1,000 and 1,200 calls a month from women in the greater Metropolitan Toronto area who have endured assault or abuse of many different sorts. Our role is to listen to women who call the helpline and assist them in making informed decisions about their situations.

Women who call us have backgrounds which include childhood abuse, incest and sexual abuse, as well as recent violent assaults. Under this clause, we would be unable to suggest to a caller that there might be a connection between the memory of these events in her life and the present crisis which caused her to call the Assaulted Women's Helpline, particularly in so far as the woman has trust and confidence in our knowledge and abilities.

For example, we are well aware of the connection between incest trauma and self-injurious behaviour. Under this clause, we would be unable to suggest that the incest a caller suffered is related to her current "dysfunction," her suicidal or self-injurious feelings or actions. This makes it impossible for us to be helpful to her in developing her real options.

One of the basic principles of the Assaulted Women's Helpline is that our job is not to make decisions for women, but to empower them to make their own decisions by giving as much information as possible. This clause would destroy that relationship, creating a situation in which we know something we cannot say which might be of help to her.

Another issue for us is referral. There are times when we might wish to refer a caller to a practitioner who is not covered under this act but who has a particular skill and sensitivity to the needs the caller has divulged. Such a practitioner would be unable to diagnose our caller's complaint, or would be put in a totally untenable situation in which the client must rely on faith that the practitioner is doing something useful, since it would be illegal for her to be told what is being done and why it is being done. Again, this destroys the helpline's basic principle of putting power in the hands of the woman.

What it means for the helpline is that we cannot refer to these sensitive and, we believe, effective practitioners.

We are stuck referring to one of the regulated professions who may never have had any training and may have no insight whatsoever in the areas with which we are concerned.

Women have been controlled by abuse. It is time for them to be enabled to take back control of their lives and their choices, including which healers they choose to work with.

In the light of the serious problems this clause would cause for the Assaulted Women's Helpline and our work, we propose that it be struck from the act. We believe that the concerns which prompted its inclusion are adequately covered by the clauses which ensure that nobody may represent themselves as being a medical doctor or nurse or one of the regulated professions, with the weight that their diagnostic opinion would thus carry, unless they are properly licensed.

Mr Owens: Thank you for your presentation. One of the intentions behind this piece of legislation is, in fact, to open up the practice of medicine to women. I agree that women have been treated as second-class citizens, as I said yesterday, and that they have been prisoners of abuse.

My question is around the issue of referral. I am wondering if you could explain more fully how you see the diagnosis clause as being problematic with respect to your ability to refer to other groups or organizations.

Ms Kneen: It is a question of who would be restricted from doing what under this particular paragraph. The fact is there are numerous practitioners, counsellors in particular, to whom we would like to refer but who would be prohibited from giving any diagnoses, and, therefore we feel, probably any effective assistance to a client, the way this is written. That is the problem. They would not be regulated. These are people whose training comes from outside the regulated professions but who we believe, because of our experience and our knowledge of the field, would be effective supports for the woman. I am thinking particularly of women who are dealing with some of the more difficult areas that we encounter, the aftermath, particularly of incest.

Mr Owens: Just a quick supplementary to legal counsel from the ministry. I am concerned about how far the net goes. I wonder if we have had any opinions with respect to that, and what that opinion is. I am becoming increasingly uncomfortable with how far this legislation goes.

Mr Wessenger: Yes, counsel will answer that.

Ms Bohnen: In my answer I would like to focus on the particular concerns that you have heard now. It is our conviction that this controlled act would not in any way restrict a counsellor/therapist volunteer from saying to a woman, "Your distress may be related, or is related, to previous events in your life." The controlled act focuses very precisely on diseases, disorders and dysfunctions, so any causal connection can be drawn to events, things that have happened to people in their lives, without having that causal connection brought within the ambit of this controlled act.

Mr Owens: I guess then the problem would be if the woman says something about hands not being functional or properly functional and the person says, "Well, that is

probably as a result of abuse." Is that where the distinction would be made?

Ms Bohnen: I do not know that I quite caught the words that you used.

Mr Owens: If the client is sitting with one of the referral folks whom she has been sent to and she complains that her hands are not functioning properly because they have been broken four times, and the therapist then says, "That's probably as a result of abuse at the hand of your partner," is that where the line would be drawn?

Ms Bohnen: That would not be covered by this controlled act at all because the counsellor has not said, "Your hands are hurting you because you have arthritis." You have not identified a disease as the cause of this person's symptoms.

1410

The Chair: Would you like to ask a question or make a comment?

Ms Kneen: Yes, I would like to make one point of clarification and ask a question. One is that our counsellors are not volunteers. I believe your legal counsel used the term "volunteer," so I would like to have that clarified.

The other is, is it the intent and the wording of the act, then, to cover only physical disorders and not mental disorders of any sort?

Mr Wessinger: I think what we are examining is within the whole health field, the mental health field as well as within the physical health field. But I think the question is, what is health? I think it is the intention not to cover counselling aspects at all within the framework of this act. Certainly that is the intention.

Mr Jackson: First of all, I would like to say that this is an extremely complex and sensitive issue, but also that the health professions generally are not up to the level of awareness and understanding to treat this properly.

The first problem, as I understand it from what has been shown to me over the last seven years, and the concern from those groups associated with assisting in the empowerment of victims, is that there is documented evidence of inappropriate treatment being provided in this area. I can list several incest cases I am working with in my riding which confirm this.

The second concept that we have to be careful of here is that if the referral is to a health care professional, the law states clearly that you must contact the police. This was part of the tension that existed, I believe, between the current chairman when she was the minister and I was the women's issues critic. We had some disagreement about intervention services that are provided at a community-based clinic versus those that are provided in a hospital setting.

We have to be very careful here because this does not comfortably fit in with the health profession delivery network for victims of violence, particularly rape and incest, in terms of awareness and understanding. In fact, some of the best therapists are previous victims who have come to the point of empowerment and are in a position to help. They are not classed as professionals. I think that is at the

nub of the concern when the women's groups have contacted me about this point.

Can you can confirm that what I am saying is part of the concern here and how we are to struggle with maintaining the independence of the support groups that are involved, in various settings? It is not just with the helpline. It is abuse shelters and in certain rape crisis centres as well. There is a range of programs there that are independent of specific health profession linkages.

Could you comment about those areas, because that is where I see our problem, until such time as we have more women psychiatrists, more access to awareness in the courts and so on, which is a much more complex issue.

The Chair: I am going to intervene for just one moment with a request of Mr Jackson, and that is first, that when you are questioning witnesses, you ask questions. Second, the Chair would appreciate it if, in referring to conversations from the past, you would be more specific rather than putting words in someone else's mouth. I remember no such meeting with you to discuss the issue that you have just put on the record, and I object to your comments.

Mr Jackson: That is an invitation to clarify, former Madam Minister, the presentations that I made in the House to you in question period and at other times with respect to funding of rape crisis centres and your responses that you were expanding access in a hospital setting, and my—

The Chair: I would suggest that this discussion is inappropriate at this time and ask that you confine yourself to questions of the witness.

I am going to allow you to answer the question if you can figure out what it is he asked you.

Mr Jackson: I agree. Your understanding of this issue is not the issue.

Ms Kneen: I think the best response I can give to the question as I understood it is that, indeed, there is a substantial amount of expertise in the areas of concern that arise around the Assaulted Women's Helpline. They are not simply matters that arise from acts of violence which the woman has endured in the immediate past but those which have caused trauma. That trauma can then become a basis for later action. There is a question of some kind of diagnosis in that kind of assessment, and it is at that point that we have substantial concern because we recognize that on the one hand, there is, I understand from what you have been telling me, an intention not to include us and our colleagues under this particular clause. But if we are not specifically excluded, then I am not sure how we can go on doing what we feel it necessary to do.

Mr Beer: The Schwartz review team looked at this over eight or nine years. They have come forward with something which they feel is a balance, so it seems to me it is incumbent on us, if we are going to recommend changes, that they are clear and present and are things that, in our judgement, with other advice and so on, need to be changed.

I guess what I am still struggling with, around those who are counselling or the various people such as yourselves, is to see how what you are doing could be interpreted as somehow going against the act. When I look at the

example you have used and the things you are doing, the process would be what? Using the example in your paper about the connection between incest trauma and self-injurious behaviour: You are discussing that with the individual on the telephone, and then presumably that person later on, for some reason or other, is upset with you or whoever it is she was talking with and decides to launch a suit of some sort. That is the concern, correct?

Ms Kneen: I would assume that is the way it would happen.

Mr Beer: But does there not have to be a sense that you are, in effect, a health care professional? I am trying to see how the advice you are giving is communicating a diagnosis as opposed to a considered opinion. I think that becomes a fundamental connection, and I sense you are quite certain that the opinion you are giving is contrary to the act. What is your basis for that?

Ms Kneen: Perhaps certainty is a strong statement. I am here—

Mr Beer: Severe doubt.

Ms Kneen: —at this point in the proceedings to raise this as a concern. I am not a lawyer. I have not spent eight years studying this. Obviously it is a grey area, and I am presenting it to you in the hopes that it can be clarified and we can continue to do our work, because we feel it is essential.

Mr Beer: You are quite right, and I think everybody agrees. We want to make sure that you can continue to do your work, and I think that is why this is a concern, but I think we also have to try to determine, in terms of the concern you and many others have expressed, if this really does do all the things that people have suggested might happen and what the remedies are.

Ms Kneen: The English language is a wonderful and very slippery tool, and I am not sure what the term “diagnosis” means and whether it covers the kind of considered opinion which a professional counsellor might give to a woman in trouble. I do not know, but I would like to be really, really clear because we are very nervous about this.

1420

Mr Hope: You raise a good point, that you are not a lawyer, and as I am hearing you, as you read it, you feel you could be in jeopardy with the diagnosis clause. The way you read it, not being a lawyer—and this is what people are going to read—it is saying you could probably be in jeopardy and you do not know how far you can go. That is what you are telling us. The language itself is not clear enough for common people to read.

Ms Kneen: We would like to have it clarified, if that is not the intent of the law.

The Chair: Thank you very much for your presentation. During the course of these hearings, if there is other information that you think would be helpful to the committee, please feel free to submit it in writing.

Before I call the next witnesses, Mr Jackson.

Mr Jackson: It strikes me that this particular deputation lends itself to a response from the women's directorate, part of the current government, and I am not 100% sure if

they are one of the directorates that we are checking with in this regard. I know we are checking with disabled persons and the ministries of Community and Social Services and Health for follow-up meetings—

The Chair: If you would like to make that request for the meeting of the 17th, that is duly noted.

Mr Jackson: I would appreciate if that could be noted or requested. It would not be a long meeting, but this seems to be the major focus of that ministry at the moment.

ONTARIO SOCIETY OF PUBLIC HEALTH DENTISTS

The Chair: I would like to call the Ontario Society of Public Health Dentists. We would ask that you begin by introducing yourself to the members of the committee. You have 20 minutes for your presentation, and we would ask, if you would, to leave a few minutes at the end for questions from committee members.

Dr Williams: I am Birt Williams. I am a dentist, graduated in 1964, University of Toronto. I work at Brant County Health Unit as its director for dental health services. With me today is Dr Patricia Main, a colleague who works at North York as their dental director. We want to thank you today for allowing us an opportunity to talk on section 3 of Bill 47, An Act respecting the regulation of the Profession of Dental Hygiene. We wish to present to you our concerns as they relate to the scope of practice of dental hygienists.

Under the act, as it now reads, a hygienist could set up an independent practice and, without restriction, provide preventive and therapeutic services without either supervision or instruction from a dentist. In all public health programs the provision of community dental services is delegated to dental auxiliaries with direction, sometimes of an indirect nature, because we recognize the hazards that are inherent in both the procedures that are performed for patients and in the agents that are used.

The provision of preventive or therapeutic clinical services, as simple as they may appear, is not without risk. Improper use of fluoride rinses and tablets, for example, could result in enamel fluorosis, which is an irreversible condition. Some topical fluorides are of sufficiently high concentrations that they could produce morbidity as well as mortality if swallowed. The apparently simple act of polishing teeth without the required medical history, as well as the ability to interpret the implications, could generate medical problems of a serious nature. These risks are reduced or eliminated if the clinician has adequate knowledge to understand the nature of the agents that are being used, as well as an understanding of how and why existing medical conditions may dictate an alteration in or redirection of a treatment plan. A decision whether to treat or not, to seek consultation or refer a patient involves knowledge, training and skills beyond those that hygienists now possess.

The Ontario Society of Public Health Dentists feels that it is appropriate for public health dentists to delegate some duties to dental hygienists. This position was well represented in the attached brief submitted to the Health Professions Legislation Review. This is based on the rationale that a public health dentist is equipped, because of his

training as a dentist, to diagnose and plan treatment effectively for both individuals and communities. We feel strongly that all treatment provided by a hygienist should be under the direction of a dentist. In public health this may be achieved through standing orders, defined performance standards and reporting mechanisms, clarification by telephone and regular on-site inspection of performance.

In the area of dental health education the information provided must be timely, accurate and reliable, and must be based upon properly conducted and understood statistical evidence. Training in epidemiological and statistical methods are an integral component of the provision of community dental health programs. Dental hygienists do not possess the necessary background in these areas. Thus, in order to evaluate or interpret research materials, they depend on accurate information and the direction of a qualified, competent dentist who has had specialty training in these areas.

By being able to delegate some responsibilities to dental hygienists, community dental programs can achieve more cost-effective delivery of publicly funded programs than would otherwise be possible, while protecting the patient and the public. Should a dental hygienist operate as an independent practitioner, there would be increased risks to patients from allowing a person with insufficient knowledge and skill to provide services that have the potential to create health problems for the recipient.

Most effective and efficient care is achieved when the dental hygienist functions in collaboration with the dentist. It is our contention that comprehensive patient oral health care, whether individual or community-based, cannot be achieved if the dental hygienist is an independent practitioner.

While we are required to speak to Bill 47, I would ask Dr Main to comment very briefly on a section of Bill 49.

Dr Main: Bill 49, in fact the entire new legislation, has quality assurance as a major thrust, and public health dentists have felt that was something they could embrace wholeheartedly. Attached to the brief is a document we have prepared to try to further define the scope of practice of public health dentists as a specialty and the ways that continuing competence and quality assurance might be measured as a help to the college in looking at this non-clinical specialty. We thought you might be interested in having a look at that and we commend you for the inclusion of quality assurance for all health professionals.

Mr J. Wilson: Thank you for the presentation because I found your comments on Bill 47 to be interesting. I am just looking for a clarification. The way I read the scope of practice for dental hygienists and their controlled acts is that in all cases, at least in the controlled acts, those acts are performed on the order of a dentist. Could you just clarify your comments about some of the things they are able to do that perhaps are not on the order of a dentist? I know you are looking at the definition of the scope of practice.

Dr Williams: Two things seem to be contradictory. You are looking at section 4, is that correct?

Mr J. Wilson: Yes, sections 3 and 4.

Dr Williams: They say they can do these things: scaling of teeth, root planing and curetting of tissues on the order of a

member of the dental college. But under scope of practice, you will notice that the first section says, "The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and, on the order of" they can do some of these other things.

Mr J. Wilson: You raise a very good point. I was just wondering if we could have a comment on that from legal counsel. It seems to me the first part of the scope of practice is simply a definition and that where any act takes place it is on the order of a dentist. But perhaps I am wrong.

Mr Wessinger: I will let counsel clarify that for you.

Ms Bohnen: I think you were correct in your understanding. The intention is that the controlled acts authorized to dental hygienists—scaling teeth, root planing, orthodontic and restorative procedures—do require the order of a dentist. However, in addition to that, the review believes that dental hygienists do not require an order to do such things as teaching proper dental hygiene, participating in preventive dental health programs, performing procedures which in the review's opinion were not sufficiently hazardous to warrant making them a controlled act, and specifically, applying topical fluoride, as an example.

1430

Mr J. Wilson: And those procedures, I understand, would be further defined by the hygienist college, with approval from the ministry, through regulation.

Ms Bohnen: The controlled acts authorized to dental hygienists which require an order are as you see them. What other activities dental hygienists may engage in, and the standards with which they will do them, you are right, are the domain of the College of Dental Hygienists, and if they appear in regulation, then they are reviewed and approved by the Minister of Health and the government. But this does leave a sphere of independent practice for dental hygienists in the sense that they do not specifically require a dentist's order to do low-risk, non-invasive procedures.

Mr J. Wilson: Thank you for the clarification. I understand then, it is the witness's intention that all acts should be under the supervision of a dentist?

Dr Williams: Not necessarily supervision, but certainly on the order. The business of providing a topical fluoride is not without serious risks in some cases. This business of polishing your teeth does cause something that is known as bacteremia, which could be serious if the person is at risk.

Mr Beer: In the way you practise currently through the public health units, how do you direct the work of the dental hygienists? I gather in some cases it may be direct but in others it is some other form. How is that determined? What do you mean by that kind of link?

Dr Main: When we talk about hygienists being supervised by direction, we are really talking about having standing orders, having clearly laid out procedures, bringing staff in on a regular basis and calibrating, standardizing what they do; checking their knowledge base, being available to answer questions at all times so that when they have a patient for whom they really do not know what a medical condition is, we are there at the end of the telephone to talk to them; doing on-site visits, doing the regular checkups,

doing quality assurance with them; not physically present at all times, but very much controlling what they are able to do and really understanding the limits that we place on it.

Mr Beer: In other words, a dental hygienist can go, for example, into a home for the aged through the public health unit and work with someone there, with a resident; but how would that contact be made? Would that come through the public health unit? I am just trying to see how that connection is made so that there is an essence of control over what that individual is doing.

Dr Williams: Basically the dentist would most likely do the examination of the person, decide what has to be done and decide if the treatment can proceed by using a hygienist.

Mr Beer: In that case, it would be the dentist who would say: "All right, there are a number of people here, some of whose teeth are essentially fine. What I want is that they will be visited so many times per year and I believe a hygienist can do that," and so that order would be set out.

Dr Main: It would not be a written order.

Dr Williams: Medical history is extremely important in these cases. You can say: "Patient 1, 2, 3, 4, it's all right, you can go ahead. Patient 5, I need to consult, so you can't go ahead."

Mr Jackson: I note with interest your point in the second paragraph on page 2 that there is more cost-effective delivery of publicly funded programs with community dental programs. That is under the current matrix, most of which is institution-based for the elderly, but as we move more to a model of hospital in the home and home-based care, how do you see the supervision of the hygienist operating in a person's home? How do you see that working, or has there been any consideration about extending delivery to that level?

Dr Williams: I could not see any difference in the way the person is going to be controlled. As a dentist, you are the one who is really going to be in charge of what happens. It is a question of delegating. Once the person is in a situation where the work can be delegated, there is no reason why it cannot be delegated, but there has got to be some control over who is going to be treated by the hygienist.

Mr Jackson: But when you are delegating, for the simple act of accountability, in an institutional setting the dentist can be on site, and where there is a questionable case, then the dentist can visit the patient. It is quite cost-efficient in an institutional setting. It is not cost-efficient if the dentist has to be called in to visit a person's home because the hygienist, upon a regular visit, indicates there is a problem or he or she needs guidance and direction.

Dr Main: Can I perhaps clarify something for you? When we are working in institutions, there is not normally a dentist there at all. We are working in homes for the aged, collective living centres. There are no dentists there. There are no dental personnel attached to homes for the aged in most cases. So we would be the dentist. It would be us that would have to be the dentist. As the public health trained dentist, we would be the one setting up the orders. It is really no different whether it is a hospital in the home or a

CLC, a community living centre, because there would not be a dentist regularly there.

Mr Cordiano: I would like to deal with the contention you make with respect to hygienists who, you say, use the fluoride rinses, which could lead to an irreversible condition. Mortality could result in the improper use of fluoride. What you are saying is that a hygienist should not be able to do these procedures unsupervised, without an order by a dentist.

Dr Williams: Yes.

Mr Cordiano: In your opinion, that is too much of a risk?

Dr Williams: Some of them are. Some of the topical fluorides are pretty high-risk materials. Rinses are not to the same degree. This is why they can be delegated even to volunteers, if you can find them. But things like some of the topical fluorides, they are pretty high-risk, yes.

Mr Cordiano: I would just refer that to the ministry, with the view, I would assume, that hygienists would have reached a standard of practice that would mitigate against something like that happening and therefore the review must have felt it was safe enough to proceed. Correct?

The Chair: Mr Wessenger.

Mr Wessenger: I would refer that question.

Ms Bohnen: Some things are so low-risk you can buy rinses over the counter in a drugstore and swish them around in your mouth. Other things are usually found in dentists' offices and places where health professionals work, and people like dental hygienists are trained to use them appropriately.

Mr Cordiano: In other words, the review felt it was not inappropriate for them to carry on with procedures independent of supervision.

Ms Bohnen: The review thought the topical application of fluoride was not sufficiently hazardous to restrict it to anybody. The dental hygienists have told you: "It is hazardous. Restrict it to us without an order." This group of dentists is saying to you, "It's so hazardous that not even a dental hygienist should be able to do it without a dentist's order." Okay?

Mr Cordiano: Very good.

1440

PRISON FELLOWSHIP OF CANADA

The Chair: I would like to call the Prison Fellowship of Canada. We would ask that you introduce yourselves and leave a few minutes at the end of your presentation, if you would, for some questions from the committee.

Mr Stanley: My name is Ian Stanley. I am a licensed minister in Canada and also the executive director of Prison Fellowship of Canada. My associate is Mrs Donna Stirling, who is the director of communications for this organization. I would like to read our submission to you, and then, as has been suggested, if you have questions, we will try and answer them for you.

The premise: Prison Fellowship of Canada, a national registered charity working with prisoners, ex-prisoners, young offenders and their families, expresses grave concern

over the wording and implications inherent in section 26(2)1 of the proposed Regulated Health Professions Act, 1991, known as Bill 43.

It is acknowledged in section 26(2)1 of the act, known as the diagnosis clause, that the words "disease," "disorder" and "dysfunction" are necessary when making an assessment. However, the present reading of this section does not differentiate between assessments made by regulated and unregulated health care practitioners. Therefore, the potential exists for disgruntled clients, not the government, to prosecute all unregulated workers because they are not excluded and/or identified within this diagnosis clause.

Recommendation: There is another option which can allow unregulated health care practitioners to make assessments without facing the possibility of prosecution. Rather than enter into a lengthy discussion to define and interpret disease, disorder and dysfunction in the assessment process as it relates to regulated and unregulated health care workers within the present wording of section 26(2)1, unregulated workers can be protected from prosecution by an addition under section 26(2)1. We therefore recommend the following:

"26(2)1a. Section 26(2)1 refers only to those regulated workers defined as a 'health profession' as set out in schedule 1 of this act. All others (unregulated workers) are not bound by the terms, conditions or prohibitions of this act."

Now some background: Section 26(2)1 of Bill 43, the diagnosis clause, describes a controlled act as occurring when an assessment of a problem is shared with an individual, by identifying a disease, disorder or dysfunction. To clearly define the words "disease," "disorder" and "dysfunction" used in this section of the act is not important for the continuance of reputable and much-needed services to individuals or family units by the professionals as set out in schedule 1.

The regulated health care workers set out in schedule 1 cannot possibly address all of the social and psychological needs within Ontario, by virtue of the sheer volume and magnitude of disorders and dysfunctions prevalent, not only within institutions but in both rural and metropolitan areas.

The repercussions of this bill within our criminal justice system are unfathomable. Correctional facilities are bulging as crime continues to escalate. Without unregulated practitioners, Ontario does not have enough regulated mental health practitioners to handle the overload.

While we are convinced that the present government of Ontario will not consider the prosecution of unregulated health care practitioners, there exists a grave possibility that juveniles incarcerated in open or closed facilities under the current Young Offenders Act, as well as all persons incarcerated in federal and provincial prisons and detention centres in the province of Ontario, will openly test in the courts the present working of this section for the simple purpose of disrupting the political and judicial process and/or destroying an unregulated worker to whom they have taken a dislike. For example, there are tens of thousands of unstable clients in our youth, provincial and federal correctional institutions in Ontario, as well as those under parole supervision. In Kingston alone there are nine

federal penitentiaries, and I believe they house approximately 4,000 inmates.

If this law is passed as is, all government of Ontario and government of Canada employees, including salaried religious chaplains, correctional workers involved in inmate assessment, ie parole officers, and social workers will be placed in jeopardy as unregulated health care workers.

There is no doubt that the current wording of paragraph 26(2)1 will be tested in the courts once the understanding of it becomes common knowledge within all strata of society.

If the words "disease, disorder and dysfunction" are not defined by the act, the courts will be left to define them. If some solution is not found within the present wording of this section of Bill 43, the counselling and support services now enjoyed by Ontario through its social workers, ministers of the Christian faith and other religious orders, crisis centre counsellors, correctional staff, young offender workers, etc, will be in a position to be prosecuted and fined \$25,000 and/or jailed for six months, or both.

In addition to the unregulated professions identified above, government employees involved in policymaking which results in the writing of new laws could be liable under Bill 43 because they will have to make assessments about social and personal dysfunctions and disorders in an attempt to address social ills.

Conclusion: Any person actively involved with another, in which there is an attempt to affect rehabilitation, makes an assessment. Assessments of individuals suffering from disease, disorders and dysfunctional behaviour must include the mental and emotional as well as the physical diagnosis.

Prison Fellowship is specifically engaged in addressing disorders and dysfunctions within the prison community and/or their relatives. Institutions have more than their share of people feeling guilt, shame, bitterness, anger, depression, etc. Most individuals who are incarcerated in either adult or juvenile facilities come from dysfunctional families in which drugs and alcohol, abuse, neglect and illiteracy reigned. But in making this statement, an assessment has been made.

Prison Fellowship's work across Canada is conducted on a weekly basis in some 44 penitentiaries. We could also include detention centres and provincial prisons as well as federal. It is conducted by carefully trained and screened volunteer workers who engage in dialogue with inmates to help them address the causes of their incarceration and how they might correct their thinking and behavioural problems upon their release.

Prisons, along with untold other institutions, depend heavily on the assistance provided by volunteers because of budgetary cutbacks and staff shortages. To place such valuable community resources in jeopardy would not only damage clients but place upstanding citizens at considerable risk because treatment by unregulated health care professionals would be unavailable.

Prison Fellowship programs have been recognized by federal and provincial correctional authorities as being needed and effective in bringing about positive behavioural changes among those clients with whom we have worked. The current wording of this diagnostic clause

would place this and all other vital community service/volunteer organizations, we believe, in jeopardy in Ontario.

Mr Beer: This issue has been the dominant one today in particular and I am not sure whether as the day goes on I am getting clearer or more confused. Suffice it to say that we recognize that if you and others who have been here believe there is a problem, then we have to find an answer to the concern because it is not our intent, the previous government, this government, the third party, all the members of this committee, to in effect wipe out the kind of service—

Mr Stanley: Unregulated workers.

Mr Beer: —that goes on. In trying to deal with it, we have had a number of recommendations and I am just wondering if perhaps you are aware of some of them that were provided by the Coalition of Unregulated Practitioners.

Mr Stanley: No, we are not.

Mr Beer: Is it your sense in trying to deal with this that it would be best simply to have some kind of exemption made or do you have some advice? I appreciate it is not up to you to define the wording exactly, but do you have some advice how we might approach this?

Mr Stanley: We had a number of meetings in our organization to discuss what is the most practical way, the easiest way of providing not only protection for those receiving counsel—which is what this government is attempting to do, and I do applaud that; I think that is very valid—but we have left this other area of the unregulated work, and it seems to me, as we have studied the act, that paragraph 26(2)1 is pivotal in this debate.

1450

Mr Beer: Yes.

Mr Stanley: I do not think it would be, in our opinion, in the government's best interest to begin to define "disease, disorder and dysfunction." That is our personal opinion because you get into interpretation and definition and it goes on and on. Therefore, what we are saying is can we make an addendum to 26(2)1 by simply saying this act applies to the professionals as listed in this act, but it exempts unregulated workers in this field?

Maybe that is too simplistic for the government, I really do not know, but it is an approach. It is a recommendation that we are making to you as a committee to pass on to the government for serious consideration.

Mr Beer: That has been mentioned before. Let me just explore it. There is a certain logic to doing it that way, but then how is one protected? Where does the protection come if someone who is unregulated in fact provides a diagnosis, or however you want to call it, which in fact leads to some kind of harm? Again, we are probably saying that 99% of people are going to act in an appropriate manner, but we still have to be conscious of the 1% that does not.

My initial concern with having that sort of clause is, how then does one deal with those who are unregulated who may provide a "diagnosis" which leads to—

Mr Stanley: I think the problem we are faced with here is that to try to cover within some form of legislation all the possibilities that may occur is an enormous task for

the Legislature. It is almost impossible. I think at some point the government has to say: "This is where we are going on it. Let's put the bill into practice and let's see what happens with these unregulated workers to see if there are any real complaints coming from that particular source of counselling." If there are, then you have something more tangible to work with, do you not, in making modifications to the bill.

For instance, I would just like to draw your attention to section 28 of Bill 43, because that has a specific bearing upon Prison Fellowship inasmuch as we are a Christian, religious movement across Canada providing that kind of counsel as well. Section 28, if I may read it, says:

"An act by a person is not a contravention of subsection 26(1) if it is done in the course of... (c)"—and this is the area, 28(c)—"treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment."

I would really like to talk to the person who wrote that because I would like to find out from this government what it means by "spiritual means." We acknowledge in Canada, by the fact that we are operating under the Constitution of Canada, that Canada is a religious pluralistic society. For instance, in Ontario right now the Wiccan church, or the church of witches, is sitting on the interfaith committee and is allowed to give counsel to prisoners in the provincial prisons.

I do not want to prolong this; we say God bless everybody, but can you imagine what kind of counsel that group provides? All of a sudden, when you talk about "prayer or spiritual means," you open up the entire, shall I say, Pandora's religious box because I am sure whoever wrote that has studied every religion being practised in Canada and is fully conversant with what they mean by "spiritual means." It is too broad, and this is the problem we are faced with. How do you provide bona fide protection so—

Mr Beer: I appreciate the point you make there and it is interesting to think of some of the implications, but one of the submissions we had today was from the Consumers' Association of Canada, the Ontario wing, which asked us to go back and revisit the question of the harm clause. In its view, that was necessary and we should not leave it out. But of course, many organizations in the various fields have been saying, "No, that shouldn't be here." Now it comes back to your point about the balance.

Mr Stanley: It is the balance.

Mr Beer: I quite agree that we cannot protect all of the people all of the time, if I can turn Barnum and Bailey up on—

Mr Stanley: That is the position we came to in preparing this brief.

Mr Beer: None the less, in your judgement there is an ambiguity in paragraph 26(2)1, where the bias could lead you to be taken into court as opposed to leaving that out or changing it, exempting or having some other clause?

Mr Stanley: That is right.

The Chair: Thank you very much for your presentation. We appreciate hearing from you. If you have any additional

information you would like to share with the committee you are free to do so in writing at any time.

Mr Stanley: Would we receive the findings of this committee—inasmuch as we have made an official brief to the government—the recommendations of this committee to the House?

The Chair: This committee will be examining the legislation clause by clause and then reporting that legislation back to the Legislature, at which time it will be up to the government House leader to order it for third reading. That is all part of the public record. At the completion of these hearings the documents of the final appearance of the bill will be available to anyone who is interested in seeing it. The clerk is going to give me an explanation. The bills, as passed following third reading in the Legislature, will be available in the government book stores. There are full Hansards of these proceedings—

Mr Stanley: My point is, I do not want to be phoning up the Ontario government every day to find out the status of this bill. The fact is that this committee will know where it sits. Then I would appreciate this committee, if it would do us the courtesy, making this information available to us or having somebody in Parliament making it available to us so we would have an opportunity to respond before the third reading. That is my point.

The Chair: These public hearings are expected to conclude and we will commence the clause-by-clause examination of these bills—

Mr Stanley: As a committee?

The Chair: At the committee, approximately around the time the House comes back into session, which will be at the end of September; September 23 the House comes back. We will be in clause-by-clause discussions through September and likely October. If you contact the clerk's office some time in mid-October, the clerk can tell you at what stage we are in clause by clause and when approximately we expect to be completed, or when you should call back to find out the state of the process.

Mr Stanley: Okay, we will make a note of that, thank you very much.

Mr Beer: It is a sort of witches' brew, is it not?

Mr Stanley: It really is.

The Chair: The process can be very confusing to people who are not familiar with it and we are happy to give you as much information as we can so you can make appropriate representations.

I would like to call now on Candida Research and Information Foundation. They are not here yet. Is CUPE, Ontario Division, here now? No? In that case, the committee will adjourn until 3:15. The committee stands in recess. Excuse me?

Mr Beer: Madam Chair, if one of the other groups is there, could we just go ahead if they are ready?

The Chair: The other presenters are CUPE, Ontario Division, and the Action Committee of Counsellors, Analysts and Psychotherapists. They are not here yet, either. We have a few minutes. If there are any questions that anyone would

like to address to the parliamentary assistant, this might be an opportunity for discussion on some of the issues.

1500

Ms Haeck: One of the things I am becoming aware of is that there are a number of groups who have come forward, possibly under the umbrella of the unregulated health care workers. I was just wondering to what degree they may have made their concerns known prior to this time, or what sort of consultation they were involved in prior to these hearings.

The Chair: Mr Wessenger?

Mr Wessenger: I think I had better give that to staff. They were here before me.

Mr Burrows: During the period of the review I think it is safe to say that the focus was essentially on the people to be regulated. Major consumer groups, one of whom we either have heard or will be hearing from later this afternoon, were participants in the review. But the unregulated groups really, I think, realized the potential impact when the actual recommendations of the review team came down because the focus then changed to looking at the overall impact.

Since that time we have had extensive consultation with various subgroups and groups such as Dr Evans's group that presented this morning. They have been forthcoming with a substantial number of options. I again think it is safe to say that at this point none of them is perfect. There are various degrees of imperfection and it is this task that the committee is presently charged with, and trying to strike that balance has been the difficult thing to capture. But there has been no shortage of input. We have not met with each of the very small groups independently, but I believe we have met with umbrella groups that have represented some of the smaller groups that are presenting.

Ms Haeck: Does that include those groups of people who might be requiring attendant care?

Mr Burrows: Yes, and there is also another level of dialogue that occurs. For example, within the bureaucracy we have had discussions with those areas that are responsible for the disabled, and senior citizens, and they have in turn had two-way communication with the interest groups they deal with on a regular basis. There has been a pretty broad network, I think, of sharing. In terms of some of the more recent developments that we heard about this morning, for example, I know Linda was involved in a meeting last week with a number of the groups where specific wording was discussed on one point. We are certainly not in a position to recommend to the minister a conclusion of that process yet, but we are actively involved in some of those discussions.

CANDIDA RESEARCH AND INFORMATION FOUNDATION

The Chair: The committee will resume and call Candida Research and Information Foundation. Please introduce yourselves. You have 20 minutes for your presentation and we would ask that you leave a few minutes at the end so that committee members can ask questions.

Ms Boucher: I am Barbara Boucher.

In the interests of clarity and in order to establish communication, I would like to declare my understanding of Bill 43,

and that is that any practitioner who is not regulated would be forbidden to enact certain designated activities. Is that correct?

The Chair: Controlled acts.

Ms Boucher: Yes, controlled acts. Is that accurate?

The Chair: Mr Wessenger?

Mr Wessenger: Yes, that is accurate.

Ms Boucher: If I am to draw some implications, number one, it would mean that any unregulated professions, were they not to become self-regulated, would have to cease practising?

The Chair: Mr Wessenger?

Mr Wessenger: No, that would not be the case, as I understand it, at all. That would not be the case.

Ms Boucher: All right.

Mr Wessenger: There would still be a role for the unregulated professions.

Ms Boucher: As you can tell, I think that is an area of concern for the public. I would like to draw out possibly five points that would be of interest to this particular group.

First of all, many people's thoughts and beliefs in what healing or being well and healthy is about, relate to some of their convictions around religious, if not educational, material. I think, in this society, were we to limit people's choices in terms of how they want to prevent illness or choose their religion or be educated, we could not constitutionally defend limitations. I think the public feels there definitely has to be the right to choice in this particular area of choosing how you want to stay well and prevent illness. It would be unconstitutional to deny that right to the public if you were dealing in areas of religion or education. Perhaps the same standard would be appropriate here.

Second, I can appreciate that there might be some concern for the kinds of abuses that are potentially capable of happening if practitioners are not regulated. I would hasten to add that our attention has been drawn to that quite a bit lately with what has been happening in the medical profession regarding abuse. Most of the unregulated practitioners are not OHIP-covered and they would not survive without people being willing to pay hard after-tax dollars for their services. I cannot imagine any of them surviving unless, number one, they were providing a valuable service and, number two, in the event of abuse, people would simply cease and desist paying hard, after-tax dollars. So I think the concern in that area, while it may be appropriate on an exception basis, does not appear to me to be an appropriate guideline to make rules.

A third area where I think it is valuable to provide some evidence, is that there have been instances where an insurance company has paid upwards of \$10,000 a year for allergy serums—these are after-tax dollars—dealing with allergies and related immune system deficiencies, things that fall under the general purview of chronic fatigue syndrome, candidiasis. After the use of various modalities that are not necessarily OHIP-covered nor recognized under regulated professions, the cost became zero. I can speak of that honestly because that is my personal history and I have seen evidence of that time and time again within the

network of people who are now exploring candida immune systems, etc. So I would suggest to the government that it is in everybody's economic interest to stop spending money on things that do not work, and to realize some of the very profitable gains in the area of productivity.

There is some insurance company out there that is not paying \$10,000 any more, and I can assure you, after 30 years of following OHIP and the traditional medical system and recovering health completely—that is my own case—but more particularly, since the Candida Foundation was featured on national TV, we have handled over 4,000 inquiries in the space of nine months. When we appeared on TV Ontario four and a half years ago, they had 72,000 calls, attempts, which has not been equalled since the time of that airing.

It is very, very clear that the public demand is there. When we hear news reports of the lineups for cardiac surgery in the hospital system and the number of hospital beds being closed down, it just does not make sense to enact legislation that would limit the capacity of the system to supply some complementary alternatives at a time like this when the existing system is so clogged. Our largest problem at the foundation is not to promote demand. Our greatest need is to be able to deliver supply and find a sufficient number of unregulated practitioners who can give wise complementary additional advice to people to get well.

Personally, it has been difficult and sufficiently disgruntling to have spent \$15,000 after tax in each of the last five years to get well. That was not OHIP-covered, so my tax dollars are not getting any return in the OHIP benefit system for me. Just as a concerned citizen out there, that is sufficiently disgruntling. But to have this same government that provides OHIP turn around and say, "Now we're going to limit your access and choice to the very methodologies that have helped you gain your recovery," just seems so very self-defeating. I think it betrays the will of a growing segment of the population such as those who are featured on the front page of the *Globe and Mail* weekly now about their interest in pursuing self-education in methods that are working and producing results.

I would like to pause there and give an opportunity for some feedback.

1510

Mr Beer: Thank you for your presentation. I sense from your questions at the beginning that you understand this is a committee of the Legislature, made up of members of all three parties, and that we have an extensive piece of legislation here that began under one party, continued under another and is now coming forward under the third, and that the aim of that legislation at all stages has been to find a balance in terms of protecting the public and increasing access, making access to different points of health care. I think we are conscious of that and the intent is certainly not to limit.

In a sense, I suppose, if we had done this 10 years ago, some of the lobbies that are now going to be self-regulated might not have been included because there perhaps was not enough information, or society as a whole did not yet feel comfortable with providing the kind of regulation that

was provided; so there are other kinds of activities that are not going to be regulated but which, none the less, can still be done. I sense your feeling is that if this legislation went through, and I want to be clear on this, your organization would not be able to do what it is doing. Is that your contention or your concern?

Ms Boucher: I would like to make it clear that the Candida Foundation's mandate is simply to provide educational services and present information to lay people so that they can make informed choices about how they want to spend their time and money in consuming health care services. We do not diagnose. We are only in a position to say, "We're familiar with this in this field." But, indirectly, my personal shiatsu therapist, iridologist, foot reflexologist, herbalist, homeopath, acupuncturist, rolfer, nutritionist and magnet specialist are all in a position where they will not be able to provide a service. I am here as a lay person, saying "This is my personal experience and I know it is magnified in a very large circle of people who are all interested in pursuing those services."

The Chair: I have had a request from the parliamentary assistant to clarify for the record, if that is acceptable to all members of the committee.

Mr Beer: Yes, actually that was my next point.

Ms Bohnen: The government's view, and I believe it was the view of the previous government, is that this legislation will not have the effect of making it impossible for the unregulated practitioners who are listed to practise. It will restrict them in performing controlled acts in the course of providing health care services, but it will not prevent them from practising and offering their services to their public.

Mr Owens: In terms of your comments with respect to this legislation limiting your access, can you explain that a little bit further? You will still have the opportunity to see your acupuncturist, your magnet therapist and the other groups you have mentioned. I am not quite sure how you see that this legislation is limiting your ability to attend the practitioner of your choice, or in the field of your choice, more specifically.

Ms Boucher: I offer these comments and I think in the political arena people appreciate that perception is everything. As practitioners who invest several hundred thousand dollars to get themselves trained and equipped to offer services, to exist in an environment that is not supportive causes people to decide, "I'm going to go and be a waiter somewhere else because it's just easier."

I think this bill is perceived as a gesture to get around what was originally proposed that would deregulate naturopaths, which is a different issue, so I think there is a concern. You may be very clear in your intention that this will in no way affect the ability of these people to offer services. If that is indeed the case, that perception is not being received in the marketplace. In fact, the opposite perception is what is happening in the marketplace.

Mr Owens: The Ontario Naturopathic Association testified for us yesterday, I believe, and it was my understanding of their testimony that they are happy with the fact that they are going to continue to be regulated under

the Drugless Practitioners Act, with a view to working on establishing their scope of practice, again, further down the road to become regulated. I am not quite sure how this legislation is going to limit choices. It clearly opens things up and puts up standards of practice in front of the public and gives people a means of remedy if in fact some harm takes place.

Ms Boucher: What are the standards of practice that it is the government's intention to establish for each of these various modalities?

Mr Owens: That question should probably be answered by the parliamentary assistant.

Mr Wessenger: Yes.

Ms Bohnen: I want to make sure I understand your question. Was it, who will make the standards of practice?

Ms Boucher: I am curious what they are, who would make them and when they would be established.

Ms Bohnen: Each regulated profession is responsible for making its own standards of practice, which are binding on members of that particular profession. Most of the professions are currently regulated and have standards of practice already. The newly regulated ones which probably have informal standards of practice will take on more formality and legal significance after they are regulated.

Some professions have tended to write their standards of practice in regulation form, and those regulations are reviewed and approved by the Minister of Health and the government. Many professions have kept them less formal than that and have written them down but have not transformed them into regulations. But each profession in sum is responsible for its own standards of practice.

Ms Boucher: Hence the impression people have that if this bill goes through and a profession is not self-regulated, that will be imposed on them. That may be appropriate for a group of 5,000 massage therapists who span Halifax to Vancouver. Many of these modalities have four people in Canada who have been trained in the US who can offer the service. It will impose on those people an economic burden and a time-administrative burden to regulate four people in the country who provide this specialized service. I think that is not only onerous; it is not necessarily conducive to the kind of environment people need to be able to pursue these.

Ms Bohnen: I think there is misunderstanding about the breadth of the effect of this legislation and the effect it has on unregulated groups. We probably do not have time today at this committee to clarify all of that, but I or other people in the ministry, I think, would be happy to take the time with you to talk about that in more detail, if that is of assistance to you.

Ms Boucher: I am sure it would be.

The Chair: Thank you very much for your presentation before the committee today. If at any time you wish to communicate in writing with the committee, please feel free to do so. I think you have had an invitation as well to contact and have further discussions with the ministry officials.

1520

CANADIAN UNION OF PUBLIC EMPLOYEES,
ONTARIO DIVISION

The Chair: I call CUPE, Ontario Division. We ask that you begin your presentation by introducing yourselves and leave a few minutes, if you would, at the end of your presentation for questions from committee members. You have 20 minutes for your presentation. We ask that you begin now.

Ms Gignac: Good afternoon. As you have heard, we are representing the Canadian Union of Public Employees. Yosi Derman is a social worker representing Jewish Child and Family Service and CUPE Local 265. My name is Gina Gignac. I am also a social worker and I am presently the president of CUPE Local 2316, which represents the Children's Aid Society of Metropolitan Toronto. With us also is Ian Thompson, who is the associate director for social services for CUPE in Ontario.

The Canadian Union of Public Employees, Ontario Division represents approximately 151,000 members in the province, of whom approximately 30,000 practise in the field of health and social services. We do not stand opposed to the regulation of health professions and do recognize some of the benefits in the proposed legislation, but we are here to talk about some of the implications of some of the aspects of the legislation, and about how these implications could adversely affect both our members as well as the general public and some of our clients.

Mr Derman: I would like to bring to the committee's attention that everyone sitting at this table is a social worker. We have been or are presently involved in dealing in front lines with some very difficult situations regarding children, the protection of children and some of the most disadvantaged people in this society. What we have to tell you is not only an official position, it is also something we feel in our bones every day.

The difficulty we have with the wording of the act is not a direct one, but one of implication with subsection 26(2), which is referred to as the "diagnosis clause": "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion." The difficulty we find with this particular clause is the lack of definition. It seems to cast a broad net covering not only social workers but also child care workers and many other professionals in the crucial work they do.

Diagnosis of a sort is something that is absolutely crucial to the work we do. A person involved in child welfare must make a diagnosis under the Child and Family Services Act as to whether the child is at risk or not. That is something we are mandated to do. There are other types of diagnosis we do in our work which are not legally mandated but which are totally appropriate to the type of work we do, for instance, diagnosing some marital dysfunction or an individual in need of treatment for drug rehabilitation.

By training, we are very careful about not stepping on the toes of other professions. We are trained not to give

medical diagnoses, and in fact to avoid them at all costs, but sometimes we are in the position of explaining to a client a medical diagnosis. In fact, in medical settings sometimes the social worker is put in that position, not his own diagnosis but having to explain someone else's diagnosis.

This clause may well affect us in our everyday work with clients. The potential legal implications are such that, should somebody seek to challenge the work we do, we could easily have to account for our actions in court when we already have to account for them in family court, but in this case it would be a different venue. Some of the difficulties we would encounter might be, for instance, in working with mentally and physically challenged children. Sometimes these children are in our care and there is no one else to care for them. We have to make a decision as to whether this child is, for instance, in need of medical treatment or in need of psychiatric treatment. That could be construed, under the wording of this act, potentially as a diagnosis, not that we intend to give a medical diagnosis, but there is no one else to care for this child and we have to decide. Would this put us at risk in terms of this particular clause? This is a question we are asking.

In terms of the work we do, there is already existing protection for clients. The agencies for whom we work are required to have accountability and complaints mechanisms under the Child and Family Services Act. As well, when we do apprehend the child, we have to account for our actions in family court. Should this refer to us, it is not necessary because there are other means of accountability.

Just to review, our position is that the wording of subsection 26(2) is a potential risk for us in terms of our work. We are already self-limiting in terms of diagnosis. The kind of diagnosis we do is not medical and is not intended to be medical. Sometimes it is a crucially mandated diagnosis that we must do under the Child and Family Services Act and it is a potential risk to us to have wording as broad as this. That is all I have to say right now.

Ms Gignac: There are several recommendations we would like to make, the first being that it is our understanding there are going to be advisory councils put into place under this act. Given the issues that have been presented and given the fact that many of our members are front-line workers and hence have contact with the people we are talking about serving on an ongoing basis, we recommend that front-line workers who are part of the union be invited to sit on these councils and have some representation.

Second, we recommend very strongly that the actual wording in subsection 26(2) either be changed in such a way that the words "medical diagnosis" be put into place so that it is not as ambiguous as it is now, or that the wording in subsection 26(2) be completely eliminated from the proposed act itself.

In summary, we are looking at the diagnosis clause lacking some clarity, given the issues Yosi has already spoken about: that it does present some risk to our members; that we make diagnostic statements and not medical statements—but we do need to make such statements to work effectively with our clients; and that some of the language we use did actually originate in the social work field.

Mr Owens: I thank you for your excellent presentation. I think you bring another perspective to the argument as to whether social workers want to be regulated. What we have heard to date is that they do want to be regulated. You present some compelling reasons for not wanting to be regulated.

My question is around your proposed solution to the diagnosis clause and using the word "medical." Where do you draw the line between "medical" and "non-medical," especially in the areas of emotional disorders? I think you would be walking a fairly fine line. I am not sure I understand your rationale for using that terminology.

1530

Mr Thompson: I think your point is well made, and in some ways we would be much more comfortable with the removal of the diagnostic clause altogether, because it is not clear to me where the line is. In my former practice as a social worker I could tell you where the line is. If I am describing family dysfunction, whatever terms I might use to do that, if I am talking about a child who is being sexually abused or physically abused and the emotional impact of that, I can tell you the line. The fact is, that does start to cross into psychiatric diagnosis, which could be construed as medical diagnosis.

When we looked at this piece of legislation, I think we looked at some of the advantages that it might possibly bring and tried to find some kind of compromise that would allow a greater legislative regulation of some acts and still protect our members.

One of the other solutions presented in our paper is that some kind of language could also be inserted similar to the language in the Child and Family Services Act which prevents prosecution or persecution of people for acts performed in good faith.

Mr Beer: Earlier today we had a presentation from the Ontario Association of Professional Social Workers. One of the things they raised was whether, as social workers, you should be within the ambit of this legislation, with your own council and so on. The other was that if not, then they recommended a social work act.

You have appended to your presentation the presentation you made to the Ministry of Community and Social Services in 1989, and I just wanted to be clear because that is several years ago. You had some concerns and doubts about whether the profession should become organized in the way the OAPSW had proposed. Could you just give us some guidance in terms of your position today, either in terms of being under this act or having your own act and thereby protecting you from some of the problems you see with this?

Mr Thompson: I think our position has not substantially changed since 1989. We still have the same concerns. The one that is raised there is that for the most part we are employees, so we are not in a position of being able to regulate our practice. The implications of a social work act and the implications of project legislation and the way OAPSW presented the notion of a social work act really ignores the fact that we are employees and that in a sense we have other reporting mechanisms that we are responsible

for and very severe limits on the way we can control our practice. For example, if my supervisor says, "Take another 30 cases or take another 5 cases," I cannot really turn to him and say, "No, that's bad practice, because I don't have time to do it."

I think OAPSW only represents a certain portion of the social work community, and we as legitimately represent another portion of the social work community. When we speak about being encouraged or allowed or invited to participate in advisory councils, we have a very different perspective and a very valuable perspective, because when it comes right down to it, we are the ones who deliver the service. I would think that less than 5% of our membership belong to OAPSW.

Mr J. Wilson: Did I hear you say that the Child and Family Services Act actually mandates you to conduct a diagnosis? Was that the act?

Mr Derman: Certain types of diagnoses, including whether this child is at risk, because it is the worker and the agency that is ultimately responsible for deciding whether this child should remain at home or be put in a foster home or some other treatment facility.

Mr J. Wilson: Does it, within the context of that act, define what a diagnosis is, or is it referring to what would be understood as a social work diagnosis?

Mr Derman: We have to judge if the child is "in need of protection," and then we have to substantiate that. We have to legitimize that before a court within five days of the child being apprehended.

Mr J. Wilson: And it is the understanding that the court understands that you have undertaken a diagnosis in that sense and you are there to justify it. We have a real problem with the terminology of "diagnosis." We have been at it for a couple of weeks now, so—

Mr Derman: The court sees it as our legitimate, legally mandated role to do that. I do not think the question is whether we are diagnosing or not. We have to make that determination. No other agency is mandated to do that. There are other types of diagnoses that we make. Interestingly enough, some of the terminology that has been developed in social work practice has been taken over by the medical practice and now it would seem that those things are considered controlled acts and we can no longer use them, potentially, under this present wording, and this is another concern of ours.

Mr J. Wilson: That is a good point. Thanks.

The Chair: Did you have a supplementary, Mr Beer?

Mr Beer: I have a question—perhaps for information through the parliamentary assistant. I had forgotten—and I am glad you reminded us—that in the Child and Family Services Act there are some protections for social workers in the line of duty, or however it is worded. My question is this: It has been the contention that paragraph 26(2)1 does not in fact cover the kind of work that the social workers are saying they do. Is that partly in relation to acts like the Child and Family Services Act where there is specific reference to protections? I am trying to get a connection, if there is one, in that regard. Or would the argument still be

that, whether that was in the Child and Family Services Act or not, this still did not relate to social work?

Mr Wessinger: I will let counsel answer that.

Ms Bohnen: I have not read that act very recently, but I think what is being referred to is the requirement that a social worker make a determination whether a child is in need of protection. Where a social worker does that, the social worker is immune from prosecution. But I think we should re-read the act and come back to you with anything from it.

Mr Beer: I would be interested in that.

Mr Hope: I will pass, being that Mr Beer has already got to the questions I was going to pose.

Mr Owens: A quick question around the application of the section on the Child and Family Services Act. Are you aware of any jurisprudence with respect to whether this—I gather it is a defence—has been successful? I guess my question is, has it been tested?

Mr Thompson: To my knowledge, the tests have been somewhat different and so they do not answer that question. I do not think there is good jurisprudence relatively and frequently, and primarily it is civil cases.

The Chair: Thank you for your presentation. If there is any additional information you think would be helpful to the committee at any time, please feel free to communicate with us in writing.

Mr Derman: I would like to thank the committee for listening.

1540

ACTION COMMITTEE OF COUNSELLORS, ANALYSTS AND PSYCHOTHERAPISTS

The Chair: I would now like to call the Action Committee of Counsellors, Analysts and Psychotherapists. Begin your presentation by introducing yourselves to the committee. You have 20 minutes for your presentation and we would ask that you leave a few minutes for members of the committee to ask you questions, if you wish.

Mr McKenna: I am Philip McKenna, a psychotherapist in private practice. I am joined by Geraldine Fogarty, psychotherapist in private practice, Robert McKay, a trainee in psychotherapy and someone who has been following the progress of this legislation from the beginning. Geraldine will begin by going over the brief, which you have in your hands, and I will pick up when we come to recommendations.

Ms Fogarty: This brief is being presented on behalf of the Action Committee of Counsellors, Analysts and Psychotherapists, ACCAP. We formed solely in response to this legislation when it was introduced by the previous government. Our membership is made up of a variety of unregulated mental health professionals who work in private practice, distress centres and government-funded health care institutions, and we number over 400.

Today we wish to express our concerns and to offer suggestions, specifically concerning subsection 26(2) of the Regulated Health Professions Act, the so-called diagnosis clause, but also with regard to the potential reintroduction

of any form of the so-called harm clause. While ACCAP members are generally supportive of the Regulated Health Professions Act and are aware of the need to protect the public from unscrupulous and unqualified practitioners, we are greatly concerned about the wording, which places all unregulated practitioners in an uncertain or untenable legal position simply by doing their job.

In the current draft of the legislation our concern is focused on the diagnosis clause. If made law, this clause would mean that anyone other than a member of a regulated profession who does something described in the diagnosis clause would be in violation of criminal law and would face up to six months in jail or a fine of up to \$25,000. The clause reads as follows: "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual, in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on this conclusion."

This clause makes it illegal to do something which is an integral part of our work. Counsellors, analysts and psychotherapists communicate hypotheses, assessments and conclusions regarding disorders and dysfunctions all the time. Sometimes this communication is very clear and direct. In the case of a substance-abuse counsellor, the communication that "You are denying the fact that you are an alcoholic" must be accepted by the client if treatment is to proceed. If section 26 remains as it is, this counsellor will just have broken the law.

Sometimes the communication of a disorder or a dysfunction may be much more hidden. ACCAP comprises a variety of different types of mental health practitioners who communicate assessments in different ways. For some, communicating the nature of psychological problems can be quite subtle. Sometimes clinical terms, as such, are not used at all, and the assessment diagnosis is communicated in less theoretical and more accessible language.

For example, a therapist might say to a client, "The alienation that you feel in your present life is rooted in the isolation which was characteristic of the relationships in your childhood family." Then the direction of the therapy in this case would involve a process where, with the help of the therapist, frozen feelings of childhood gradually begin to thaw and over time the person begins to risk forming close relationships in his present life. This is a very common kind of procedure.

In addition to the original assessment connecting present feelings of alienation to childhood isolation, over the course of this therapy the therapist would be consistently directing the person back to childhood feelings, thereby consistently recommunicating the original assessment. This might happen in almost all the sessions for a time. Therefore, the clause affects not just a one-shot diagnosis but the course of the whole treatment. In this case, as with the substance-abuse counsellor, the therapist has crossed the boundary outlined by subsection 26(2), as we see it.

In both of the above examples, healing will involve working with fragile and vulnerable feelings. Trust is an indispensable element in such a process. It is the presence of just such trust, however, which is precisely the type of

circumstance in which it is reasonably foreseeable that the individual or his or her personal representative will rely on this conclusion. In some cases, the therapist may be the first person the client has ever really trusted, in which case the therapist's assessment would have great weight for a time. In the course of the therapy this weight would lessen as the person came to rely more on his or her own conclusions and his or her own understanding of things.

Further, studies of the effectiveness of psychotherapy have concluded that the rapport between therapist and client is the biggest single determinant of success or failure, regardless of the brand of therapy being used. Many clients, especially those coming from alcoholic and other highly dysfunctional families, have grown up among mixed messages, equivocation, secrets, pretences and denial, and they can spot hedging and equivocation a mile away. The trust required in the relationship between the therapist and the client, if healing is to take place, must be rooted in mutual respect. In such a relationship—in fact, in any viable relationship between two people—the therapist must be free to be honest and straightforward.

The present wording of subsection 26(2), however, if passed, would make honest and direct communication to a client very risky. The therapist in each and every case of such communication would be breaking the law and be subject to a jail term or \$25,000 fine. Regardless of whether we were persecuted, most of us would be guilty of criminal offence on a daily basis. The thought of it makes me nervous and it makes 400 other members of ACCAP nervous. Nervous therapists do not do good therapy.

We have been reassured by the ministry of the previous government and by the ministry of this government that this is not meant to be an attack on unregulated health practitioners as such, nor is it meant to chill them in their work. But this clause, if passed, would have just such an effect. It would on me.

Who and what are we frightened of? Two possibilities come to mind immediately. The first is a situation where the therapeutic process itself might have broken down. An example might be the kind of person who is angry, possibly harbouring lifelong resentments, and who sees in the therapist an authority figure with whom he can get even. A second threat might be the reaction from disgruntled relatives. Here the therapy process is proceeding well, but the people around the client do not like the changes that they see and that are influencing their lives. Parents or spouses, particularly in dysfunctional relationships, can become frightened and angry when once-docile people start to assert themselves. Invariably they blame the therapist: "Everything was all right until she came to see you."

Even though such situations may not be frequent, they do occur, and they are difficult enough as it is. With section 26 on the books, the possibility of ending up in court is real.

It seems absurd to a reasonable mind that an intelligent judge would want to convict any unregulated health practitioner to six months in jail in a circumstance like the ones described above, based on subsection 26(2), yet the law would be on the books. Ultimately, the question the members of ACCAP face is: Which one of us is going to be the test case, with all the time, the expense, the worry, the

damage to reputation, and, not least, the impact on the rest of our clients as we are trying to deal with this, which a court case would entail?

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The Chair: Thank you very much for your presentation. Are you continuing?

Mr McKenna: Shall I continue with the other part, then?

The Chair: Yes, please do.

Mr McKenna: We had four suggestions of possible ways to change the diagnosis clause. I suppose my own first wish would be that you scrap it, as you did the harm clause, and maybe for the same reasons—that as it stands it is pretty much a basket clause and there is no nuance in terms of its respect for ordinary people's own judgement as to where they go for help and so on. It is an attempt, through the legislation, to control everything. I think that is a useless enterprise in general.

If we talk about possible ways of amending it, one suggestion on page 4 is to attempt to identify which disorders and dysfunctions are to be strictly left to the regulated professions. This then gets into some attempt to draw a line through language, through the terminology that we are going to be regarding as the sort of language used in diagnosis and the sort of language which remains publicly usable by people like ourselves who are unregulated.

This might have some future if the area of mental health were clear and uncontroverted, but since the 19th century there has been an ongoing controversy about all the psychological disturbances and whether they are organically based or psychologically caused. There is no hope to get that clear in the legislation, absolutely no hope. You either have to use a sort of basket approach and say that everything that is ever written down in the DSM 3, which is the diagnostic manual, any word that occurs in there can only be used by regulated professionals; or you have to go to just a few agreed terms.

This brings us to number two, in a certain form, where we would suggest you try to say exactly what kinds of disorders you are talking about. The only path I could see there would be if you went to an extreme pole and said something like "disorders that were physically life-threatening," or something like that—things like cancer, heart attacks, things that actually bring about death. Because, as I said, if you get into the area of mental disturbances like schizophrenia, which are soul-threatening if not physically life-threatening, there is no agreement on what causes these things. Leston Havens, a psychiatrist, an authority at Harvard, says that a word like schizophrenia does not name a disease; it is a syndrome, and we do not know what is under it. We gather together symptoms and we do not pretend to know what is under it.

The clause as it is hopes that out there the medical profession knows exactly what is under everything, and they would hope that anybody treating mental diseases knows exactly what is causing them. We do not; nobody does. We cannot get it in the legislation. You cannot stop people trying to struggle with this new area—it is still new; it is 200 years old, but it is still very new—where we

are on the frontiers of trying to work out the meaning of these troubles, the causes of them, the appropriate treatments. It is certainly not the role of a Legislature to try to pretend that what is unclear is really clear and could be regulated.

So that is number two, which would be saying something like "only diagnosis of a physical kind." I would say even that would not work because some psychiatrist would say, "Well, that means the whole area of mental health." But you might say, "Physical diseases causing death." That might get you somewhere.

The third idea was to protect the title; that is to say, as long as you do not claim to be a doctor or a psychologist or an optometrist, then you are okay. You are not doing a diagnosis in the sense that this is getting at.

Fourth, and this seems to be the way that people who wish to retain this clause mostly go, is some form of competency barrier. If we go that way, I think we need to express in the clause that it is only gross incompetence that could be challenged in the court. There should be some kind of seriousness in terms of damage caused by such a diagnosis before it could ever come to court. So there would need to be a double barrier to frivolous prosecution of the kind that my colleague explained in her examples.

Finally, the harm clause. We just heard that it stays out. It is a basket clause. It causes harm and would certainly bring about a kind of chill in the unregulated professions. Thank you very much.

Mr Jackson: Without further exposing my own personal eclectic background, I have a working knowledge of Gestalt and the Esalen Institute in California and various therapists there, and know of their work in this province. Knowing that, I have a certain respect for the very delicate kind of work you are doing. You can start out treating a dysfunctional marriage and end up with a deeply rooted discovery of child sexual abuse. These are very sensitive areas. You strike, really, at the root of the concern of where you place yourself. Yet the community at large accepts the fact that your work is meeting with significant results.

With that in mind, and knowing that Ontario is trying to break some new ground in terms of regulating, do you know of any jurisdictions that are proceeding in this area and have dealt with it differently than we are, because my fear is that you will be included.

Mr McKenna: I do not know of any jurisdiction—

Mr Jackson: With that leading edge in terms of penetrating into this area for regulatory purposes.

Mr McKenna: For regulation, I do not know of any.

Mr Jackson: That is what I was afraid of.

Mr Ruprecht: In order to make the diagnosis clause more acceptable to you, you went on to establish in your recommendations what you call the competency barrier, to catch the people who are not competent. Can the accusing party be brought to the point where they would have to indicate beyond the shadow of a doubt that an incompetent practitioner has made a wrongful decision? How do you see that taking place in front of the courts?

Mr McKenna: Supposing somebody brought me to court because, say, they have cancer and I say to them:

"Look, you do not need to go to the doctor's. They are just terrible in what they do to you in their treatments. What you need to do is go through visualizations and fight the cancer with me and I will help you." I stop them going to the doctor. I use my authority as a therapist to suggest to them a kind of treatment for their physical illness. Now, if they brought me to court, I would say that they would have a good chance to prove me grossly incompetent in the judgement that "This is the only way you should work. This will cure you."

1600

Mr Jackson: In other words, you are able to live with this incompetency clause?

Mr McKenna: Yes, but I think gross incompetence should have to be proven. In other words, to avoid frivolous challenges that might come from disgruntled people, you would need to put a strong onus on either the terrible damage that has been done, and that it was grossly, not just a bit, incompetent.

Mr Ruprecht: Just briefly.

The Chair: Sorry, Mr Ruprecht, time is up.

Mr Ruprecht: I see some relationship between Professor Evans's presentation and yours and it might be a good idea to continue in those discussions.

The Chair: Thank you. I very much appreciate your presentation before the committee. If there is any additional information, please feel free to communicate with us in writing.

PATIENTS' RIGHTS ASSOCIATION

The Chair: I would like to call now on the Patients' Rights Association to please come forward and introduce yourselves to the committee. You have 20 minutes for your presentation. We would ask, if you wish, to leave a few moments at the end so that committee members can ask questions.

Mrs Coy: I am Anne Coy, co-founder of the Patients' Rights Association. In case some of you do not know us, I would like to point out that we were not formed with the idea of punishing any practitioner who fell short of giving—the term we commonly use is "adequate care." I do not like it; if you fall short of adequate, you are inadequate. But simply because, after the death of my husband, whose death was hastened by a medical intervention, the college seemed to think that the only reason I approached them was because I was bitter and not because anything had happened in the course of his care.

Our approach through the years has been to bring about a correction of behaviour rather than the punishment of a practitioner. My view was that it was an avoidable medical accident and let's take some steps to avoid it recurring. I was not very successful. I cannot say, after working on this project for 17 or 18 years, that I am successful now, but I am still trying and we are here.

I would like to hand over the following presentation to my co-workers, we are all volunteers, David Coburn and Harry Beatty.

Mr Coburn: Our focus is almost entirely on the complaints and disciplinary procedures involved in the legislation. I would like to begin by making a point about the process through which this legislation was arrived at. The process we feel was one dominated by professionals. During the long process they took to form this legislation, I was often in a room with perhaps 200 or 300 other people, I would say 280 of whom were health professionals, who were eager to get the rights and privileges that medicine already had, yet there were very few consumer representatives.

Let me refer to a statement by the Minister of Health of the time when I think the bill was introduced into the Legislature for the second time: "Mr Speaker, over the years of this legislation's evolution, most of the consultations have been dominated by professional groups. To consumers I want to say that now it is your turn to speak out." So I hope this committee will take consumers' points of view seriously, and not hesitate to alter this legislation or to consider it as being written in stone.

As we have mentioned, the patients' rights group has been in existence for a large number of years. What we have done, basically, is handle patient complaints and inquiries; that is, people who have had complaints about physicians or other professionals. Mrs Coy herself has handled hundreds of inquiries. She has personally processed dozens of complaints through the college system and has appeared before such boards as the Health Disciplines Board. Our experience is practical experience. It is not just what is written in the legislation. Incidentally, I am sure that Mrs Coy would not want me to mention it, but because some people are involved in the process, I would like to announce that today she has been informed that she was the recipient of the Ontario Medal for Good Citizenship for her work in this regard.

[Applause]

The Chair: On behalf of the committee, we would all like to congratulate Mrs Coy, especially in view of her own modesty. I think that the people in the province of Ontario are very grateful to her for her efforts on behalf of individual and patient rights over the years. I think all of us here, from all three caucuses, are delighted at the recognition of your efforts.

Mrs Coy: Thank you.

Mr Coburn: As Mrs Coy mentioned, the aim of the Patients' Rights Association should be to try to get feedback from patients, in order to help improve the health care system. What we want to do is make sure that small problems do not become bigger ones. We feel that a very good complaint system will help improve the quality of health care in Ontario. I think the suggestions and comments that we make are reasonable ones because we made a submission to the Minister of Health in 1977, and almost all our comments in that recommendation have been supported by major commissions and committees since that time, including the Krever Commission, the Prichard Commission on Malpractice, and the more recent task force on sexual abuse of patients. We are not alone in our point of view and it is supported by official commissions and committees.

Now, a few minutes on our general approach: We cannot make all our specific recommendations today, but hopefully we will in written submissions to the committee. I want to make the point that this legislation solves a lot of problems for the professions but it does not solve the problems of patients. Let me take the viewpoint of patients in the health care system. Something happens which they do not like. What are they faced with? They are faced with three options. They can sue; the Prichard Commission generally shows that very few people, even if they are justified, take that option and even if they do, hardly any are successful. For example, lawyers cost \$500 simply for an opinion as to whether a case is worth taking or not.

The other avenue is through the college system and we can document that. The College of Physicians and Surgeons is our major example. The college system does not adequately deal with complaints. Let me give you an example. In one period of time, of 3,000 complaints made to the college, only 300 were heard by the complaints committee. Of those, I think about one in four or five actually ended up in the disciplines committee where there is a formal hearing. Of that number, hardly any were judged guilty. So, what we are looking at is, at various time periods, of the complaints handed to the College of Physicians and Surgeons in Ontario, about 0.8% to 1% of the complaints actually result in a doctor being disciplined for some reason. From our point of view, this shows that the procedure is not adequate.

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The other avenue is, of course, a formal complaint procedure. I would just like to mention that there is no legislated formal procedure or obligation whatsoever to hear patients' complaints in hospital. The hospital is the place where a lot of health care takes place, but there is no formal procedure there. Hopefully, the Ontario Public Hospitals Review will provide a formal complaints procedure in hospital.

So what we are saying is that a patient is faced with these three alternatives. None of them is adequate and the whole system is unco-ordinated. There are major problems with this procedure of patients making complaints to the colleges. For one, thing the public views the colleges as protecting their own members, and despite the fact there is some lay representation in the college, the public perceives the college to be antagonistic to them before they even submit a complaint. I would say that many people do not submit a complaint simply for that reason. We do not think the complaints committee investigations are adequate. Often this consists simply of the following: The patient will write a letter to the college, the college will ask for a written response from the doctor, and they will make a decision on the case simply on that basis. That is not always the case but that happens quite often. We do not think that is enough.

There is nothing in this present legislation to legislate the colleges to advertise their disciplinary function. If I am in Wawa or Brockville or even Toronto, how am I to know that the College of Physicians and Surgeons is the place to direct my complaints? With the addition of the 23 other colleges, you can imagine how complex it is going to be for the public to decide where this complaint is going to go,

or whether the colleges have this function. There is nothing in this legislation, as I see it, either for patients or health care providers to be made aware adequately of their own rights or responsibilities. Health care providers are not aware of patients' rights and many patients are not aware.

One of the major difficulties with the legislation proposed is simply the multiplicity of colleges. Patients to whom something happens in the health care system often do not know who is responsible or who is at fault. They do not even know that the person who did it is a physician. Imagine the patient faced with 24 colleges in which there may be one or more health professions involved. They may have to process their complaint through two or three or four colleges. At the same time, what if these colleges arrive at contradictory conclusions. What if one college says, "Oh, it is not the nurse, it is the doctor" etc. We feel the multiplicity of colleges is simply making the process of patient complaints more complex, rather than easier.

Just a few more words, and then Harry can take over. We feel the process is too cumbersome, expensive and complicated. We are advocating a single, central agency outside the college system to handle complaints. The health disciplines would be self-governing in every other respect, other than complaints. I would argue that, just as some people do not believe that the police can adequately investigate cases of police brutality, we do not think that the colleges can carry out an adequate investigation of their own members. If there is not an independent agency, at the very least we think there should be a single agency to whom patients can direct their initial complaints, so that at least they have some direction as to what to do about it.

If the legislation is carried forward, we think it should be a mandated duty of the colleges to make their own members aware of patients' rights, and to make the public aware of their disciplinary function, every one of the 24 colleges. We think there should be full disclosure reporting of the disposition of all complaints and disciplined cases and the reasons for these. For example, the college now reports its complaints and disciplines but does not report how many inquiries or how many complaints it initially received, so the information is not complete.

The professions themselves currently define misconduct and negligence, and it is unclear, I think, to doctors, to other health care workers and to the public what the colleges view as misconduct. I want a clearer definition, even if it is only through precedent, of what the colleges regard as misconduct.

Finally, the college councils are often composed of people who were previously association or union representatives. For example, you can be a chief executive on the Ontario Medical Association one day and a member of the council of the College of Physicians and Surgeons of Ontario the other. I hesitate to mention in this room the doctors' strike in Ontario, but many members of the council of the College of Physicians and Surgeons seemed to have difficulty in deciding what was in the public interest during that particular episode.

I think that is all I have to say, even though there are many particular points we might want to mention later.

Mr Beatty: Just to add a few very brief things to what David said, on page 3 of our brief we outline in point form some of the problems that have been apparent to us and to complainants for many years. Many of these points which we have been putting forward for about 15 years are reiterated in almost the same terms in the report of the task force on sexual abuse of patients chaired by Marilou McPhedran.

Essentially the complainant, who may be concerned about the death of a family member or about being permanently disabled or sexually abused, very serious matters, is required to go into a system that is controlled by the very profession of the member whom he or she is complaining against from the beginning. The colleges control everything from intake. It is someone at the college who talks to you initially about the case. They control the investigation, they control whether there will be a hearing at all that you could go to. At the hearing, of course, members of the college and employees of the college or people retained by it both conduct the hearing and conduct the prosecution.

Of course, the individual has no party status, not even intervenor status. Even talking recently to counsel involved in cases, including sexual assault cases, an attempt to represent the complainant in any way is met with a lot of opposition both by counsel for the colleges—not just the College of Physicians and Surgeons but also the College of Nurses of Ontario—and clearly by counsel for the professional complained against.

David mentioned there have been several studies, but I think the major one, because it is most recent and because it talked to individuals, is the task force on sexual abuse of patients which we referred to. On page 4 we have just one excerpt. The report indicated as clearly as it could that the college has simply failed to prevent or police sexual abuse and that major reforms need to be taken. Yet we have Bill 43 with a procedural code that is almost exactly the same as the current system. The final report of this task force is due in September. There are many wide-ranging recommendations. We know that you will be hearing from the task force later on. We would encourage you to give careful attention to their reforms.

Going to page 5, David has already mentioned some earlier statistics that were analysed by a student under his direction. The most recent statistics are an appendix, from 1985 to 1989; again, the complaints committee of the College of Physicians and Surgeons. In the process, they do not give figures as to how many inquiries or initial concerns were expressed to them at intake and were screened out in some way, either because the person was not able or did not want to pull together a written complaint or was otherwise discouraged.

But however many complaints made it from intake to the complaints committee, substantially less than 10% of those got to the discipline committee. Some years it was almost as low as 5%. We do not have figures as to the actual disposition of those complaints, but very likely we have a situation where we would estimate at least 98% of the cases end without any disciplinary action. Even where there is a disciplinary action, even in very serious matters, it is only a reprimand.

Finally, we mention the Prichard report, which is the most comprehensive study done in Canada on these issues concerning professional negligence, liability and compensation. Despite the difficulties of the malpractice system, he found that if you took the number of physicians disciplined by professional colleges for negligence and incompetence and compared it to the number for whom a malpractice settlement or award had to be paid out, we are looking at only between 10% and 20%, so in fact the colleges were picking up only a very small percentage of actual malpractice and negligence cases.

I believe there was a study done by Professors Trebilcock, Dewees and one other, Coyte, at the university. Essentially, they showed in a five-year period, as best they could determine, that between 100 and 200 doctors in the entire country were dealt with in any way for professional negligence and misconduct. As I have said, in often fairly serious cases, that was only a reprimand.

Mr Beer: In your paper you say that you believe an independent tribunal is the most appropriate way to proceed, and not to have the various colleges. We had a presentation earlier today around consumer points of view. I think it is very helpful to have this, because, by and large, presentations have been from those who are within professional groups.

Is it not important, though, in this system, and one of the arguments for the colleges, that the members of the profession itself are involved in both self-regulation and really reviewing their own practice? In your proposal of an independent tribunal, how would you involve the professionals from the different fields so that they would be involved in assessing their own practice?

Mrs Coy: Under the present system in the Health Disciplines Board, completely lay people are able to get any expert advice they need.

Mr Beatty: I should also mention we do not, of course, advocate that the professions should not be self-

regulating. Of course they should be involved in education, peer review and so on. It is in the actual hearings that we feel at least some aspect of the process should be more independent, at least in some cases, rather than complete control. Just look at what happened to Mrs Yuz when she tried to pursue. That case is still going on, over a decade later, looking into the tragic death of her son.

Mr Beer: Would you see the advisory council possibly evolving into having that role or being an appeal body?

Mr Coburn: First of all, we think that colleges should be left with defining registration, certain fitness-to-practise procedures, etc. They have a lot to do regarding the self-regulation of the professions, naturally. But regarding complaints specifically, we were thinking—and we did not go very far with it—of something like labour mediation. We want to settle things at the lowest possible level, without people having to sue in order to get satisfaction. So we thought of something like a tribunal of judges or arbitrators in which both parties would meet initially and try to settle the issue at the lowest possible level, without discipline in fact. I think in many cases people do not want discipline, they want the particular behaviour corrected before someone else is harmed, and that is our desire too.

The Chair: Thank you very much for your excellent presentation. I know the committee has enjoyed hearing your very thoughtful point of view. If you have anything further that you think would be helpful for the committee in its deliberations over the course of these hearings, I know you will feel free to communicate with us in writing.

I remind all members of the committee, particularly those who have been substituting, to pass on to the other members of the committee any of the documentation and information you have received so that they will have it next week.

The committee will reconvene Monday morning at 9 am in Thunder Bay.

The committee adjourned at 1625.

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 Owens, Stephen (Scarborough Centre NDP)
 Silipo, Tony (Dovercourt NDP)
 Wilson, Jim (Simcoe West PC)
 Witmer, Elizabeth (Waterloo North PC)

Substitutions:

Huget, Bob (Sarnia NDP) for Mr Silipo
 Jackson, Cameron (Burlington South PC) for Mrs Witmer
 Ruprecht, Tony (Parkdale L) for Mrs McLeod
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Standing committee on social development

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Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le lundi 19 août 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent



Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
Greffier : Lynn Mellor

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Monday 19 August 1991

The committee met at 0902 at the Valhalla Inn, Thunder Bay.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi de 1991 sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

The Chair: Good morning. The standing committee on social development is now in session.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: I am going to call first OPSEU and I would announce some changes in the schedule. At 10:10 we have the Handicapped Action Group. OPSEU filled a spot that came available when we had a cancellation, so you have 10 minutes for your presentation. We would ask you to leave a few minutes for the committee to ask questions, if you would. You can begin your presentation now, please. Welcome.

Ms Pycko: I am Anne Pycko, president of Local 734. I work at St Joseph's Hospital. I am a lab technologist. Fran Zaitz is a lab technologist, Bev Dalys is a research education officer for OPSEU and Bob Reid is a respiratory therapist.

On behalf of the 10,000 OPSEU members who work in health care facilities across the province, I would like to thank you for the opportunity to express some of our views on Bill 43, the Regulated Health Professions Act, and on its companion bills. Because this legislation will spell out different consequences for different OPSEU members, we have chosen to focus on specific concerns in each of our presentations to this committee.

The task of developing a provincial health care system which will address many outstanding weaknesses in our current system is by no means simple. The Health Professions Legislation Review carried out by Alan Schwartz beginning in 1983 and which brought us where we are today responded to concerns raised by many groups. Among the concerns was that brought forward by hospital administrators, who wish to make more efficient use of their staff. It is this point that we will address today, as OPSEU is concerned that the review's response to administrators will have a negative impact on the integrity of the work done by our members and the conditions under which they work. It will breach the quality of health care that Ontarians have come to expect.

Restructuring the delivery of health care in Ontario has been a priority for the three governments that have been in power over the past eight years. During this time our health care crisis has intensified. All three governments have been forced to grapple with the conflicting goals of equalizing and preserving a system of quality health care for all Ontarians, preparing for the needs of an aging population and containing the high cost of health care. Many of the interim solutions we have seen come under the rubric of government divestment. At OPSEU we feel these changes have had a negative impact on the quality of health care and on the health care worker. OPSEU is now concerned that the legislation under review, the Regulated Health Professions Act, will be yet another component of divested health care.

In reviewing the materials concerning the impending changes in health care, particularly the ministry's briefing to this committee two weeks ago, two words come up repeatedly: flexibility and competition. Given the geographical realities of Ontario, we expect that the government will search for ways to provide better service to people in rural areas. This is where the idea of flexibility is reasonable. If the authority of on-site health care workers is extended in such a way as to enable patients or clients to get the help they need when they need it, certainly that is beneficial. OPSEU, however, has some very serious misgivings about the downside to this flexibility, particularly when it is defined in terms of competition and privatization.

If there is any one area that demonstrates how flexibility and its counterpart, competition, can harm the public and reflect poorly on a profession, this area is laboratory technology. OPSEU members are currently having problems in laboratories because work that properly belongs in the hands of registered technologists is delegated to non-registered laboratory technicians. The volume and cost of these tests have led administrators to the conclusion that this cost-cutting is an absolute necessity. It is, however, the technologists, not their assistants, who are responsible for the accuracy of the test results. In hospitals and in private labs where administrators are closely watching budgets, they may be losing sight of something else: quality service. This means that the numbers of well-paid registered technologists are dwindling while non-registered technicians take on tasks for which they may not be properly qualified.

Under the proposed legislation, these current problems will be exacerbated and the registered technologists will carry the responsibility. Given that laboratory technicians are not covered by and cannot be charged under this act, we are very concerned about technologists who seldom have control over task delegation but are responsible for outcome. We are further concerned because it is already fairly standard practice for laboratories to get by on skeleton staff with as few qualified technologists on hand as possible. Opening

the road to even more competition in this underregulated field will be devastating for the public and for the profession.

Accurate results from the laboratory are the foundation of patient management and protocol. Inaccurate test results can lead to serious errors being made by other health care professionals. As a basis for nursing assessments, laboratory results will become more crucial in patient management. Mismanagement and underevaluation in the laboratory can ripple throughout the health care setting, with tragic results. Clearly it is crucial that the work being done in laboratories be respected for its role in the health care system, and the critical task for which the laboratory technologists have been specifically trained should be deemed controlled acts. OPSEU represents other highly trained health care workers whose specialized tasks will not be deemed controlled under this legislation. We will turn our attention to these groups in a later presentation.

The excessive pressure under which registered technologists are currently working has become their primary concern with respect to working conditions. Lab technologists who are carrying the responsibility for the results of work they never assigned to the technicians are in a terrible bind. This is a terrible inconsistency and, as we have said, an inconsistency which contributes to the high stress level. Workers should not be responsible for work over which they have no control—that is, work they have not performed and that they have not assigned to others. If we are to properly protect the public and rectify this outstanding and worsening problem, quality provisions must be enshrined in this legislation.

The concerns we have just raised about accountability are exacerbated by the pressure put on hospitals to stay in the black, the ever-increasing attempts of hospital administrators to cut costs by cutting corners, the trend towards privatization of medicine that we are seeing in for-profit laboratories and, most recently, the government's action to open the way for more competition in medicine.

0910

While we laud the government for seeking ways to provide more service in rural areas, we believe upholding competition as a legitimate factor in health care delivery is an ill-conceived concept and one which may have tragic consequences for all Ontarians.

As we have said, this is complex and far-reaching legislation, and while your committee is meeting with interested groups across the province, so too is OPSEU continuing to meet with its affected members. We are planning to have more concrete proposals to present to the standing committee on social development in a written submission towards the end of this month.

We thank you for your time and welcome any questions.

The Chair: Thank you very much for your presentation. Question, Mr Owens?

Mr Owens: The Ontario Society of Medical Technologists raised briefly in its presentation the issue around grandfathering. Do you think grandfathering is an issue this committee should be concerned with, and do you have any thoughts on its potential effect on health care in this province?

Ms Dalys: Grandfathering is certainly an issue that OPSEU is concerned with. It is actually one of our biggest concerns, and for that reason we are deferring that till a later presentation. To answer your question a little more specifically now, we know that the work that is being done by lab technologists who have been in the field for 30, 25 or 20 years—however long, but for a long time—are doing a good job.

Technology has changed. Qualifications have become more standardized and more education-oriented. Certainly the people who have been doing those jobs for a long time are doing quality jobs, and they have to be caught up in this legislation. That, of course, applies to a lot of other professions as well. We will be addressing that in more detail at a later date.

Mr Owens: Any idea how many people we are talking about at this point?

Ms Dalys: Not really, no. I will get the figures for you at a later date.

Mr Owens: I would appreciate that. Thank you.

Mr J. Wilson: Thank you for the presentation. You mentioned that there are certain controlled acts that you think should be included in this legislation for laboratory technologists. Can you give us some examples of what those acts would be?

Ms Dalys: I am going to pass that question over to the lab technologists that we have here. They are the professionals. I will mention that we have been discussing that with some of our technologists already. We have not come down with a definitive list.

Ms Zaitz: Because OPSEU is representing so many different professions right now, as Bev has said, we are looking at what controlled acts will be expected to be passed off to different members. I cannot say just simply as lab technologists, quality assurance, assessing, the reportability of test results. My specific specialty would be analysis of drugs, testing body fluids. I do not want to specifically aim right now at any particular one because I might exclude someone who is actually just as important.

Mr J. Wilson: You are planning on including this in your next submission that you will be putting forward later?

Ms Zaitz: Yes, we have a set of other presentations. Yes, we will be.

Mr J. Wilson: Thank you, that would be helpful.

Mr Hope: Just to point out some of the concerns you have dealing with watching the budget, competitiveness, privatization—and you indicated later on in your brief that you are going to be sending the committee more substantial information dealing with it—will you be concentrating on the rural area or will you be doing it as a global OPSEU presentation?

Ms Dalys: We are looking at a global picture of it. It is difficult that competition and flexibility are flip sides of the same coin. We know the geographical realities of Ontario. We know that somehow service has to be provided in smaller areas that do not attract the same kinds and numbers of professions that you get in bigger centres.

What we have difficulty with is selling off health care to private enterprises where cost-cutting becomes—well, it is just so central to the whole idea of business. We have spoken to technologists in one private lab who were saying they have been told in that lab to finish up all the reagents before they buy more and it does not matter if these reagents are expired. That obviously has a very negative impact on health care. It creates bad results.

I think many of us remember reading stories about the United States when lab technology, for example, was divested. Cytology labs started hiring unqualified people to look at slides. They were paid on a piecework basis and cancer rates shot up because a lot of abnormal cells were not noticed on earlier swabs. That is the danger. That is something we cannot afford to have happen here.

Mr Reid: Excuse me, just to add to what you were saying about the control-factor part of it being employed by an employer, they set the setting, they set the working environment for us. Also, with the condition that the health care is in right now, as far as its finances are concerned, that sets a scenario for the working conditions too, so basically, as an employee, you have no control over your working environment. Then to be legislated upon as being responsible and being addressable for your actions as a therapist, a technologist or as a health care professional out there, it puts you in that jeopardy situation where you are responsible for something you have no control over. That is one of the things we address.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee this morning and we will be looking forward to your written submission when it is ready.

For the information of everyone here, groups and individuals are encouraged and welcome to communicate with the committee in writing over the course of the hearings. I know you will feel free to do that.

GEORGE FIEBER

The Chair: I would like to call now George Fieber. Welcome. You have 10 minutes for your presentation and we would appreciate it if you would leave a couple of minutes at the end for questions from the committee.

Mr Fieber: My name is George Fieber. I am a registered nurse and I work in the intensive care unit of a general hospital here in Thunder Bay. I also work as a clinical instructor, teaching nursing and nursing assistant students.

It is my intent today to present my concerns regarding the Regulated Health Professions Act and specifically the Nursing Act from my perspective as a working nurse, as a nurse educator and as a consumer of health care services in northwestern Ontario. As a nurse employed by a hospital and as a member of the Ontario Nurses' Association, I fully support the position of the ONA regarding this proposed legislation as it was articulated by ONA president Eileen Davidson during her appearance before this committee on August 7.

For the sake of brevity, I will not review the ONA position except in regard to the problem of double jeopardy, as it was identified in the ONA review of the draft legislation. The double jeopardy referred to—that is, my

being responsible to both my employer and the College of Nurses of Ontario, whose standards often conflict—has created and will continue to create situations where I must make decisions where I weigh my professional obligations to my patients against the demands of the administrators who employ me.

If no resolution is found to this dilemma and the proposed legislation is passed in its present form, the possibility of fines and imprisonment for making the wrong decision will add more stress to an already stressful job. The safety of patients may be compromised.

0920

As a nurse educator, I believe the Nursing Act should explicitly state that nurse administrators, educators and researchers should be fully accountable to the College of Nurses. As an educator, I have a great responsibility to ensure that the nurses I train can provide safe, competent patient care, and if I fail to do this properly, I should be held accountable to a professional body, expert in the standard of practice expected in my profession.

This question of patient safety also demonstrates the need for nurse administrators to be accountable to the college as well. The decisions of these management nurses in areas of staffing, policy and procedure have direct impact on patient safety. Accountability for their decisions might also reduce the occurrence of the double jeopardy situations already discussed. Accountability for nurse researchers would help ensure that research would be conducted in an ethical, professional manner and that patient safety or privacy would not be compromised.

Finally, as a consumer of health care services in northwestern Ontario, I believe that the draft legislation, by prohibiting nurses from performing a single controlled act independently, will diminish the quality of patient care available to the people of this region and will in fact create situations where patients may be put at risk.

Hospitals in northwestern Ontario are not staffed like the teaching hospitals of the south. They do not have medical staff on the premises 24 hours per day. In some cases, like the hospital I work in, they share the services of an emergency department physician on night shifts and weekends with another hospital. This means that in the event of an emergency, it may not be possible to contact a physician for several minutes to obtain orders.

Time and time again, life-threatening situations have been averted by the intervention of experienced nurses who knew what to do and when to do it. Restricting the ability of these nurses to use their experience and training is an insult to them and a disservice to the public. It will reinforce the widely held belief that the people of this region are given low priority when provincial health care policy is developed and when health care resources are allocated.

In closing, I believe the public can best be protected when all registered nurses are licensed and have a defined scope of practice where the double jeopardy as employed professionals has been resolved. All registered nurses, including administrators, educators and researchers are included in the scope of practice and are made accountable to the public for their actions. Finally, as many nurses as possible are trained

and allowed to perform more controlled acts, especially when patient safety is at risk and a physician is not available.

I would now be pleased to answer any questions the committee may have.

Mr Hope: I have just a couple of concerns. I see you work in the intensive care unit of the hospital. You talk about obtaining orders from a physician. In the rural settings, do you already have standing orders that are in place dealing with patients?

Mr Fieber: There are certain protocols. For instance, I am certified in advanced cardiac life support, and there are certain protocols that I can follow. There are certain life-saving interventions that I cannot, at the present time, go ahead and do without having a physician present.

The problem though, as I explained, is—and this has happened several times over the last few years—in the event of a cardiac arrest in our hospital, the only physician who might be available is approximately two miles away at another hospital. Your only chance of making it is if I do my job properly. The problem is, at the end of my list of protocols there are certain things I can still do to save your life, but under this legislation, if I did them, I would be accountable for a \$25,000 fine or imprisonment. So you are putting me in the position of either doing what I am trained to do or letting me go.

The Chair: I have an intervention from the parliamentary assistant to clarify.

Mr Wessenger: Yes, under section 28 of the proposed act, there is an exception saying an act by a person is not a contravention if it is done rendering first aid or temporary assistance in an emergency, so emergency situations, I believe, are covered by the act. In the situation you raise, I believe you would be covered by the act.

Mr Fieber: The situation I was thinking of specifically is one of the controlled acts that—I do not know the exact wording—involves the application of an energy source. I was thinking of the application of external pacemaking, for instance, in the event of someone whose heart has stopped.

As the legislation sits now, you say I would be protected in that case. I do not think I would be backed up by the hospital in the event of an error, and I think under the present draft it is still vague enough that I could end up facing charges. If this is clarified, fine, but as I read this legislation, I understand it is quite possible I could be held liable.

The Chair: Thank you very much. We appreciate your presentation before the committee.

REV RICHARD WILLANS

The Chair: I would like to call next Richard Willans, who will be representing all Anglican parishes, northwest section of the diocese of Algoma. Please come forward and introduce yourselves. You have 20 minutes for your presentation. We welcome you to the standing committee on social development this morning. Please begin your presentation now.

Mr Willans: Thank you for the opportunity to bring before you the concerns that we have with regard to Bill 43.

I will be brief and succinct for two reasons: first, obviously, your time is valuable and I am just one person out of

many, but second and perhaps more important, the concerns I have to bring before you are not new. I apologize for that, but I present them to you none the less because I believe that if reasonable people hear the same concerns surfacing over and over again, although they may find it extremely wearisome, they will agree at the very least that there may be a problem which needs to be addressed.

My name is the Rev Richard Willans. I am the rector of St Thomas' Anglican Church, one of the numerically largest Anglican churches here in the city and indeed, in the whole of the diocese of Algoma. In addition to that, I am the regional, or sometimes called "rural," dean of our Anglican deanery here, which comprises 12 parishes and goes out to Manitouwadge.

I belong to the diocese of Algoma and I am charged, with Bishop Leslie Peterson, with the responsibility of representing to you the concerns of the Anglican clergy and our lay workers and people here.

I must add that I do not in any way claim to be an expert on the implications and ramifications of this bill. The concerns that I bring before you are those which other diocesan experts have highlighted. None the less, I do personally endorse them.

With me is the Rev Joan Mitchell, priest in charge of St Stephen's, one of the smaller, yet dynamic, churches in the north ward of this city. Joan is with me because she has had much greater experience than I have in some of the areas of pastoral care that this bill could affect, in particular having been for some time in an official chaplaincy position at the Lakehead Psychiatric Hospital.

In addition to those credentials, I think it is worth mentioning that we are also both members of the local council of clergy, and Rev Mitchell is currently the treasurer. We do not speak on behalf of the council. The council was not able to get its act together, but we do know that our concerns are the same as those of many of the individual members.

We have spoken with Mrs Lisa Strasser. She is the chairperson of a local ad hoc group of hospital chaplains and pastoral care workers charged with the specific task of making a written presentation to you in September. Because the most capable people are on vacation at this time, they judged themselves unable to make a verbal presentation today. Again, we do not claim to speak for them, but we do know that our concerns are essentially the same.

I have been using the word "concerns" in the plural, but as I understand it, there is one primary concern and I will concentrate on that. This primary concern relates to the implications of section 23, and especially clause 2, dealing with the definition of a controlled act. I will not read that, because I am sure you know it backwards.

It would seem to us that, given a strict reading of this clause and section, any clergyperson, pastoral counsellor or hospital lay visitor, to name but a few, who does something which fits the above description, would be technically guilty of a criminal offence. If that presumption is even technically correct, then many of us would be in potential trouble very quickly, given the comprehensive and somewhat loose nature of the terms disease, disorder, and dysfunction.

The above wording could logically include, for example, my suggestion to a parishioner that marital and personal

problems possibly stemmed from perhaps unresolved grief or unresolved guilt or an overwhelming sense of personal inadequacy, or that a teen was possibly in need of substance abuse counselling and so on. You are familiar, I am sure, with the scenarios, and these are just a few of the common pastoral problems that land on our doorstep, usually late at night.

As I said—you have heard this before—we know that the government has stated that it does not intend this act to be applied in a rigorous and literal fashion to creditable, unregulated workers. However, history is littered with examples of situations in which the intention and spirit of legislation has little to do with how the letter of the law has been subsequently applied. We do have a serious and sincere concern about this, particularly given the possibility of private prosecutions based on this clause and section. We do not presume to offer solutions. These are best provided by yourselves and by others who have the appropriate expertise and oversight. We do ask, however, that real consideration be given to this concern because it may affect, not just clergy and parish workers, but all those who support our health professions in countless creditable ways, yet are classified as unregulated.

Finally, just so there is no doubt in anyone's mind, we do applaud the intent of Bill 43 and support the greatest part of its particulars.

0930

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee this morning. Questions? Ms Haeck?

Ms Haeck: Actually, I think Mr Hope had his hand up first so I will defer to him.

The Chair: The reason I gave you the opportunity to speak first, Ms Haeck, is that Mr Hope has asked questions already.

Ms Haeck: Clause 28(c) talks about "treating a person by prayer or spiritual means in accordance to the tenets of the religion of the person giving the treatment..." Do you feel, in that area of this particular proposed Act, that you do have the—I am trying to choose my words carefully here—kind of safety net that you may not feel you have under section 26.

Mr Willans: I think, in certain senses, yes. But perhaps they might legally be seen to be contradictory and the one might outweigh the other.

Ms Haeck: I have met with clergy in my own riding and I know they have expressed a particular desire to be very clearly exempted from this legislation. Is that the kind wording you would like to see included in the act?

Mr Willans: I am not really sure on that because I have not thought it through. And I would need to just say that and be quite honest about it and leave it there. I do not know whether it is in our interest and in the interest of lay workers, because they are also involved in this, to be regulated or unregulated.

Mrs McLeod: I think it may be a comment more than a question. It certainly was the intention of our government, when we were initiating this legislation, to ensure

that this would not be a problem for the unregulated professions; that this restriction would not be one which would lead to concerns about legal prosecution. As difficult as it is to find the exact wording which will provide that degree of protection, the current government will also want to make sure that, as a result of the recommendations of this committee, that assurance is provided. There is an assessment clause which is quite clear in providing unregulated professionals with the ability to carry out assessment in their field of concern and communicate that assessment to the individuals who they are working with. We have to make sure there are not inconsistencies that would lead to your concern about legal prosecution.

Mr Willans: We are aware of the intention that has been stated over and over again and I referred to that in my presentation. I think my primary problem—perhaps I could sit here for a moment less as a clergyperson and more as a former history and constitutional teacher. As I said in the presentation, the intention of the law is not necessarily what happens when you get down to the letter of the law. So we are asking you to look particularly at that clause and perhaps, if necessary, tidy it up or whatever might be done so it is completely clarified.

Ms Mitchell: So we are not put into jeopardy—because, with the majority of people with whom we deal, there is an assessment, an evaluation and a referral. You cannot get around that.

Mr Hope: This is a question outside of your presentation here. By the sounds of it, you represent the northern rural area which is of particular interest to me. In your conversations with the general public, does the legislation, on the whole, look like it is going to do what it is supposed to do in protecting people from those out there who may cause problems to our health care?

Mr Willans: I have to choose my words carefully now, too. Anything which does what this bill proposes to do, in tightening up health care provisions and making sure people are not abused in any way, will do the job. That is the way I see it and that is the way other people have referred it to me.

Mr Hope: Will it meet the public concerns in rural areas about health?

Mr Willans: In terms of the concerns I am dealing with here, yes. If you want to open the whole question of health care in the rural areas, I am not even qualified to speak on whether this bill would do that job.

DANNY GILBERT

The Chair: I would like to call next, Karen Gilbert and Danny Gilbert. Please come forward now. Welcome to the standing committee on social development.

Mr Gilbert: It is only Danny Gilbert.

The Chair: Welcome Danny Gilbert. Is that because we are a few minutes early? Is Karen going to be coming?

Mr Gilbert: No, that is because my kids had an emergency dental appointment, so it is just me.

The Chair: I am sorry to hear about the emergency dental appointment but we are pleased you are here this

morning. You have 10 minutes for your presentation and we would ask that you begin now.

Mr Gilbert: Madam Chairperson and other members of the committee, I would like to thank you, first of all, for this opportunity to express my concerns regarding the proposed Bill 43. It should be pointed out that I am not a professional in any way. I am here to express the concerns I have as a parent of a handicapped child. I am in support of the bill, in general, in that it is designed to protect the consumer of health care in this province; and that protection is necessary. There is one area, however, that I feel could adversely affect not only my son, but also the thousands of other children in the province who suffer from the same syndrome, both diagnosed and undiagnosed.

First, I should tell you that my son has fragile X syndrome and my daughter is a confirmed carrier of the syndrome. Most of you I am sure have either never heard of fragile X syndrome or if you have, your knowledge is probably very limited. For that reason, I will briefly explain what it is and what affect it has on the individual.

Fragile X is an inherited abnormality of the X chromosome. In an individual with fragile X, there is a narrowing of the long arm of the X chromosome at the Q27.3 site. This narrowing of the chromosome causes varying degrees of problems for those who carry it. The effects range from mild learning disabilities to severe mental retardation, autism or autistic-like behaviours, behaviour problems, attention deficit problems, hyperactivity, sensory integration dysfunction, various medical problems such as mitral valve prolapse and a triad of physical characteristics which are: large ears, long, narrow faces and large testicles. Fragile X syndrome is the leading cause of mental retardation next to Down syndrome and the leading cause of familial mental retardation. It is also responsible for approximately 14% of the cases of autism. It has been estimated that one in 1,000 individuals are born with fragile X, yet very few are ever diagnosed with it.

This brings me to my first concern with Bill 43 and that is paragraph 26(2)1 which states: "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion." With fragile X, it is absolutely imperative that a diagnosis be given as early as possible, preferably at birth. My son was seven before he was diagnosed. The problem arises because very few doctors actually diagnose fragile X because they rely very heavily on the triad of physical features I mentioned earlier as well as the presence of retardation. Unfortunately the retardation is not always present or if it is, it is not an across-the-board retardation as is the case with Down syndrome.

To complicate the situation, the triad of physical features is not present in all FX patients and those who do have the features generally do not get them until after puberty. This can cause a delay in diagnosis of up to 13 years or can result in no diagnosis at all. My son was seen by several doctors, including a neurologist, and they all missed the diagnosis. It was not until we insisted on FX testing that a

diagnosis was made by chromosome analysis. There are two professions, however, that have been very helpful in assessing and explaining to us the symptoms of fragile X in our son. One is an occupational therapist and the other is a speech language pathologist. As the health act reads now, neither one of these professionals could perform a "controlled act," paragraph 26(2)1.

The two areas that affect virtually all fragile X children are sensory integration dysfunction and speech and language delays. Doctors do not generally do either sensory integration assessment or speech-language assessment, nor do they usually interpret the results of such assessments. This is done by the professionals in the field, occupational therapists and speech language pathologists.

Obviously, not every child with either sensory integration problems or speech-language problems has fragile X syndrome, but it is my right as a parent to know what is a possible cause of these problems. It is obviously not a definite diagnosis. My family doctor cannot give me a definite diagnosis. That is done with chromosome analysis or DNA analysis.

One of my concerns with paragraph 26(2)1 is that an occupational therapist may not be allowed to tell me or another parent that my child's problems could possibly be caused by a specific disorder or several disorders. This would not only curtail their ability to properly apply their training, but it would also cause a considerable delay in information reaching me. In the case of fragile X, it is imperative that information reach the parent as quickly as possible.

Paragraph 26(2)1, as it stands, would also prevent an occupational therapist from telling me that my son has sensory integration dysfunction, simply because it is a dysfunction that causes specific symptoms. It seems rather ludicrous to me that an occupational therapist can do an assessment on my son for sensory integration but cannot tell me that my son has sensory integration dysfunction. To have to relay this information back to a doctor is simply overtaxing already overtaxed doctors and delaying therapy that should be started as quickly as possible.

It would also seem to me that this paragraph would curtail both occupational therapists' and speech-language pathologists' ability to explain to me how a particular disorder was causing my son's problem. As a parent, it is very important for me to understand that my son's insistence on certain types of clothing is not stubbornness but, rather, it is a symptom of tactile defensiveness.

This information takes a tremendous amount of pressure off both my son and myself and allows us to concentrate on more important things. This information is essential for me to know how to properly deal with my son's other problems and to help him develop to the best of his ability.

It is also important for my son to understand that his problems stem from a physiological cause; that he is not a bad kid. It is also important to understand that a doctor or other health professional may not be aware that sensory integration dysfunction occurs in fragile X syndrome, or if they are aware of it, they may not have as much information about it as an occupational therapist would have.

I would not expect an OT to explain to me or to give me much information about mitral valve prolapse, nor do I

expect a doctor to give me much information about sensory integration dysfunction.

When I receive any information on my son, I want it to come from the professional in the field that I am dealing with. The controlled act 26(2)1 could prevent that from happening.

It is also imperative, in dealing with children who have fragile X syndrome, that a team approach be taken. For this to occur, professionals involved must be able to communicate freely with each other as well as with the parents.

The important thing to remember is a parent is the most integral part of the team. We are the ones who must co-ordinate and implement many of the suggestions made by the professionals. We are also the ones who live with our children and have the most concern for them. To help our children, we must be fully informed as to what the problems are and what the causes of these problems are. For this to happen, every professional must be freely able to communicate with us, to give us the information we need to help our children overcome their handicaps as much as possible.

Once again, the controlled act 26(2)1 could prevent this from occurring and the people who suffer the consequences would not be the professionals, they would be my children.

The purpose of the Regulated Health Professions Act is to protect the public; people like me. I believe the best way I can be protected is to be educated and informed. Some of this knowledge can be obtained by reading, but much of it comes from the varied professions I am involved with. Through them I have learned and can continue to learn how best to help my son deal with and overcome many of his handicaps. Because of this knowledge, I can find professionals who are truly qualified to help us and avoid those who are not.

It is my fear that the controlled act 26(2)1 could quite feasibly stop the stream of information and severely affect my son. I believe this possibility could be avoided, however, by the addition of a subsection to subsection 26(2).

I am sure that politicians and lawyers are much more qualified than I am to decide the wording of such a subsection. It should, however, be to the effect that regulated professionals would not be contravening a controlled act as long as the assessments and information relayed to the patient were within the realm of their expertise and training.

Such a subsection would ensure that my wife and I, as well as other parents, would continue to get the information that is actually and vitally needed to help our children.

Once again, I would like to thank you for giving me this opportunity to speak to you.

The Chair: Thank you very much for a very thoughtful presentation.

Ms Haeck: I recognize that you have become an expert on this particular syndrome out of the need that your own family has undergone. What kind of process did you undergo in order to find the experts who ultimately helped you?

Mr Gilbert: Initially we went to our family doctor. My wife is a psychiatric social worker, so we then went to a psychologist she happened to work with, who gave us

the idea of developmental delays, etc. We then went to a specialist in Halifax, Nova Scotia. We then went to a neurologist in Halifax. The information we finally got as the diagnosis of fragile X came from a lay person. Since that time, we have also been in contact with speech-language pathology, occupational therapy, etc.

Ms Haeck: I have to say that we are all definitely very much concerned about the diagnosis and communication portion of the act. We have heard from a number of people who make this presentation, but we have also heard from consumer groups who have a very strong concern about public education, about the availability of various services out there. What you are describing is probably a lengthy process through which you went as a parent to find out what problems your son was having. How do you feel that the whole public education portion for the Ministry of Health should be structured so that other people do not necessarily have to go through such a long process?

Mr Gilbert: That is actually a very hard question to answer. I can speak only for fragile X. We have started up fragile X resource centres throughout Canada. There is a new association started up, and support from the ministry for this endeavour. Whether it be fragile X or some other disorder that is not well known, to get information to people is very difficult. How it could be speeded up is hard to say, because fragile X is a disorder that has been around for ever, but it really has only been diagnosed for the last 20 years, so you are in a position where a lot of professionals simply have never heard of it before. We do get professionals from across Canada phoning us asking for information on fragile X.

I do not think it is a matter of just simply sending out more information. The professionals have got to have the opportunity to speak freely to me.

Our occupational therapist was out the other day to give us the final results on my son's sensory integration assessment. I realized when I was talking to her that if this section went through, probably most of the things she had told me she could not have told me.

With fragile X it is very imperative. By the time these children hit puberty, most of the help they can have is over with. My son is already nine. If she could not have come out and given me that information on Saturday, I would now be in the position of making a doctor's appointment so my doctor could give it to me, and I would be talking probably six months down the road, because it is not an emergency situation as far as the health professions are concerned, which it is not. It is not life or death. It affects his life, but it is not an emergency.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee this morning.

Mr Gilbert: Next time I will bring my wife.

0950

RESPIRATORY THERAPY SOCIETY OF ONTARIO

The Chair: I would like to call the Respiratory Therapy Society of Ontario. You have 20 minutes for your presentation. We would ask if you would leave a few minutes at

the end for questions from the committee. Please introduce yourself for Hansard.

Ms Bubar: My name is Dawn Bubar, and as a practising registered respiratory therapist in northern Ontario and a director at large for the Respiratory Therapy Society of Ontario, I am here to express both support and concern for Bill 43 and Bill 64 on behalf of the registered respiratory therapists of northern Ontario.

We are in support of Bill 43, the Health Professions Regulation Act, which provides for the regulation of health professions and the delivery of health care services. In general, with the exception of section 15, we support Bill 64, the Respiratory Therapy Act, which provides for the regulation of the profession of respiratory therapy by the College of Respiratory Therapists of Ontario.

As mentioned, we are concerned with section 15 of Bill 64, which covers the proposed restricted titles. Because of such concerns, we wish to recommend the following amendment to Bill 64. We request the addition of the word "registered" as follows:

"15(1) No person other than a member shall use the title 'registered respiratory therapist';

"(2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a registered respiratory therapist."

The term "registered" must be part of our restricted title, as it is with nursing, since there is a difference in the standard of education between a respiratory therapist and a registered respiratory therapist. The registered respiratory therapist is a graduate of an accredited educational program who has successfully passed the Canadian Society of Respiratory Therapists registration examination in respiratory therapy. These examinations are prepared and administered by a subcommittee of the joint Canadian Anaesthetists' Society, Canadian Thoracic Society and the Canadian Paediatric Society committee on respiratory therapy. The conjoint committee is a committee of the Canadian Medical Association.

On-the-job-trained personnel function in some health care facilities as respiratory therapists. Also, individuals who have graduated from an accredited facility but who have not yet written or who have not passed the Canadian Society of Respiratory Therapists registration exam are also called respiratory therapists. The term "registered" denotes that a specific level of prescribed education has been successfully achieved.

It is imperative for the protection and awareness of the public that the Respiratory Therapy Act, 1991, be amended as proposed. With the advanced technological practices and equipment that registered respiratory therapists are required to perform and to work with, it is imperative that the public be able to recognize, for their protection, the difference between a therapist who has received full training in all these areas and who has achieved a standard level of education, versus those therapists who have not received this level of education. We cannot emphasize this enough.

This would conclude my statements today, and I would like to say that a written submission will be forthcoming.

Mr J. Wilson: Is the term "registered respiratory therapist" what you would use now to distinguish?

Ms Bubar: Yes, it is. For those who have achieved or successfully completed the examinations by the Canadian Society of Respiratory Therapists.

Mr J. Wilson: So do you feel that this is an oversight in the act that we do not have it in there?

Ms Bubar: To my understanding, it was initially in there but it was dropped in the revisions that had been made, and therefore that is why we are back here again requesting that it be put back in.

Mr J. Wilson: Was it dropped, though, so that the act would be sufficiently broad to include those who may qualify for entry into the College of Respiratory Therapists?

Ms Bubar: I think it was dropped because they did not understand the difference between the respiratory therapists and registered respiratory therapists. I think the assumption was that they were one and the same, and we feel the distinction must be made for the protection of the public and for their awareness.

Mr J. Wilson: Would respiratory therapists, then, who do not have the title and the education of a registered respiratory therapist, require separate legislation to be registered?

Ms Bubar: No, they could still practise. They would still be under the same umbrella. It is just that we have to be able to distinguish between—as in nursing, they graduate; they are a respiratory therapist, and once they complete the examinations to ensure a standard consistent throughout the country and province, then they become registered therapists.

Mr Wessinger: I would like to have ministry staff give some clarification in this regard.

Ms Bohnen: The effect of section 15 of the Respiratory Therapy Act as proposed would be to prohibit anyone other than a member of the college from using the title "respiratory therapist" or "registered respiratory therapist." If it is your view that people who have not become members of the college should be permitted to use the title without the "registered," I would think that presents to this committee the issue of whether the public could differentiate between registered respiratory therapists and respiratory therapists. I mean, the public interest issue that the government was seeking to advance was that the public needs to have a simple way of differentiating people, and the way you differentiate them is with this title "respiratory therapist," so do not let anybody except a member of the college use the title "respiratory therapist," "registered respiratory therapist," or some other variation of it.

Ms Bubar: That would take care of those persons who are using the title but have not received any training whatsoever. However, those who have successfully completed the educational process through an accredited facility have up to three years in which to successfully complete the Canadian Society of Respiratory Therapists examinations. In those three years, they can still practise as a therapist; they just have not achieved the next level up. So by prohibiting the use of calling them respiratory therapists or from leaving them out of the college, we have no control over a number of therapists who are practising for a period of up to three years.

Ms Bohnen: If I can just go on, it depends on how the college determines the requirements for registration or various classes of registration, as a respiratory therapist. The college could certainly say, and I am just making this up, "For three years, post whatever program you take, you are registered as a provisional member of the college," and those people could still use the title. There is not a direct link between who gets to register and the title. I will stop there.

The Chair: I would like to thank you very much for your presentation today. If in the course of these hearings there is anything further that you wish to communicate with the committee, please feel free to do so in writing through our clerk. Thank you very much.

1000

HANDICAPPED ACTION GROUP INC

The Chair: The Handicapped Action Group is next. Welcome to the standing committee on social development. We appreciate your coming before the committee this morning. You have 10 minutes for your presentation. We ask that you introduce yourself first for the record and leave a few minutes for questions from members of the committee. Please begin now.

Mr Holmwood: Good morning, Madam Chairman and members of the board. I am John Holmwood and I represent the Handicapped Action Group Inc. The recommendations contained in the above-named report and the suggested regulations in Bill 43 are a serious concern to the members of the board of directors of our organization. The Handicapped Action Group is a broad-based, multi-faceted disabled consumer organization that provides non-professional attendant services—support care, if you will—to the physically disabled individuals in northwestern Ontario.

We feel that the recommendations and regulations will have adverse ramifications for all consumers in our catchment area. The entire independent living movement, including the Ontario government's commitment to community-based services, will be seriously compromised by the recommendations in the above-noted report. Presently, a number of services that this report calls "human health care services" are performed by lay individuals under the direction of individuals who are receiving the service. This service enables individuals to live independently in the community by assistance with those functions that they are unable physically to perform themselves.

Costs for these services are presently being picked up by the individuals themselves, insurance companies, the Workers' Compensation Board and the Ministry of Community and Social Services programs, ie, support service living units, outreach programs and vocational rehabilitation. Under this proposed legislation, unlicensed individuals carrying out services will be at risk of legal charges and, if convicted, fines or imprisonment.

While it is important that standards be developed, the whole area of service provided by these attendants should not be a health matter or part of the health legislation. If organizations such as ourselves are to provide comprehensive community-based service in this province, the issue related to the severely disabled adult must be appropriately addressed.

Section 28 of Bill 43 should include as exemptions to the act the following key points. These points were developed by an extensive consultation conducted by the Attendant Care Action Coalition:

(A) A relationship between a person with a disability, PWD, who self-directs his or her own service, and the attendant who assists, is unique in that all responsibilities and control rest with the person with a disability.

(B) An amendment to Bill 43 must apply only to the consumers of the attended services who self-direct their own services.

(C) Self-directing assistance with routine functions of a daily nature by reason of having a physical disability is part of a healthy, socially active lifestyle and not a health-related activity.

Legislation that looks at controlling and regulating attendant services or undermines the responsibilities of the consumer who self-directs those attendants on the basis of physical disability is discriminatory and violates the basic human rights of the persons with disabilities to live independently in the community. I thank you very much and I will take any questions.

The Chair: I have a request from the parliamentary assistant to clarify. I also have a copy of Hansard with us that addressed this issue at an earlier time during the committee. I will ask the clerk to give you a copy of that.

Mr Wessinger: Thank you very much for your presentation. I assure you the previous minister and the existing minister have both confirmed that your concerns will be attended to. It is really just a question of working out the mechanics of ensuring that this care is not affected by this act. I can assure you it is being worked on now and there will be changes to the legislation.

Mr Hope: I was just going to elaborate a little bit more, as you raised some concerns, and being the parliamentary assistant to the Minister of Community and Social Services. A number of concerns you raised deal with attendant care, as you understand, the multi-year plan, where we are trying to make sure most people are out of institutions and into the community living, and also with long-term care. It is our goal to make sure there is quality care and at the same time attendant and other care and making sure a person lives independently in the community and, as you reiterated on your concerns, as a lay group, understanding what is going on and making sure the important values of service provided in communities such as this one are essential to people living in the community. Your concerns have been echoed a number of times and we will make sure those parts of the legislation are addressed and clear.

The Chair: Thank you very much for your presentation before the committee today. We appreciate your coming forward. The committee would be happy to receive any further submissions in writing at any time over the course of these hearings.

Mr Holmwood: Thank you. I think it is on its way.

The committee recessed at 1005.

DONALD HOOD

The Chair: The standing committee on social development is now in session. I would like to call Donald Hood. You have 10 minutes for your presentation. We would ask you to leave a few minutes for questions from the committee.

Mr Hood: I am Donald Hood. I am here speaking as an individual, though I am a professional in the field of audiology in northwestern Ontario. I am actually wearing two hats today. One of them is as a private practitioner in the field of audiology in Thunder Bay, and I have been here for 13 years. I chose to come to this underserved area of the province on my own, I might add, at no cost whatsoever to the Ministry of Health or the taxpayers of this province.

The second hat I am wearing is as a co-founder of the Canadian International Hearing Services, which is a federally registered charitable non-profit organization that helps developing nations of the world establish viable, effective, efficient hearing health care services. We have been doing that since 1976, so that is 15 years. We work in an ongoing way in about 20 nations. In fact—I apologize for my slightly slurred speech—I just got off the plane from India, doing the same thing over there. My apologies in advance if I seem to lapse a bit in my 10-minute time period.

I wanted to address the issue of perhaps missing the forest when you are looking at the trees, with respect particularly to the issue of diagnosis and prescription. In the field of audiology this relates to informing the patient, obviously, about the results of the testing and then prescribing an appropriate course of remediation that is non-medical and non-surgical.

Also, I would like to touch briefly on our definition of "risk of harm," which I know this committee has dealt with probably in great depth. In the field of audiology, I jokingly say, there is no such thing as an emergency hearing test, which is one of the reasons I chose this field. I do not get called at 2 o'clock in the morning to come in to do a hearing test. We are not concerned with life-and-death matters. We are not concerned with loss of limbs. We are not concerned with matters like that.

But we are concerned with harm that can arise out of inappropriate management, inappropriate diagnosis of hearing impairment in the area of physical harm, where a person may in fact be inappropriately fitted with something like a hearing aid or an assistive listening device—something other than a hearing aid—or where the hearing aid may be too powerful and in fact cause additional hearing loss.

Then there is the area of psychological harm: If a person is fitted inappropriately he may become more depressed. He may in fact turn other people, who can benefit from a hearing aid, off seeking help because of the misfitting.

Social harm: Inappropriately fitted means they will not be able to integrate as well into society if they have not been counselled appropriately and fitted appropriately with a hearing aid or assistive device.

Vocational harm: If they are inappropriately fitted with a hearing aid they may in fact not fit back into the workplace

adequately or as effectively as they might if they had been treated and handled adequately.

Again, we are not really talking about life-or-death matters, but quality-of-life matters, and there is a continuum of quality of life. As in any health care field, when care is provided, that care provides little or no help or a great deal of help, so there is this continuum of improving the quality of life. Our objective, as health care professionals, and for me specifically in audiology, is to move the person as far as I can along that quality of life continuum, so that we do not cause physical, psychological, social or vocational harm.

I think we can best achieve this by dealing with hearing health care, as I advise other nations to deal with hearing health care, in a holistic way, by dealing with the four factors of health care. These are not new to you either: identification, assessment or diagnosis, management—or, in this case, prescription—and prevention in education. Those are the four topics we deal with internationally, and they address virtually all aspects of hearing health care and other kinds of health care as well—identification, diagnosis, prescription in this case, and prevention in education.

As with the quality-of-life continuum, dealing with these four factors is also on a continuum; each one must be addressed by the professional with four things in mind or four bits of knowledge. One is the depth of current knowledge. The second is an understanding and availability of the latest technology. The field of audiology is very young. We grew out of the Second World War. About the time I was born, audiology was born. Third, we need good communication skills to convey information to the patient, and you can only do that if you have a good background of knowledge, the number one issue that I referred to.

Fourth, you need appropriate motivation. That is to say, a person should choose to be in a caring profession to deal with all aspect of hearing loss, all those aspects I mentioned just a few moments ago, and not with the main reason of making a living from the sale of hearing aids.

When the diagnosis and prescription process is approached in this holistic way—that is, dealing with all four of those topics: identification, diagnosis, prescription or management, and prevention in education—the government of Ontario will have attacked the problem of hearing loss with the best quality-of-life bang for the taxpayers' bucks. More appropriately prescribed hearing aids, funded in large part, as you know, through the Ministry of Health assistive devices program, would be worn more often rather than left in dresser drawers. Ladies and gentlemen, there is no such thing as a hard-of-hearing drawer, but that is where they end up. Thank you for your attention this morning; I will be pleased to answer any questions you might have related to this area.

Mr Owens: The hearing aid dispensers have argued that if the legislation goes through as proposed, access to service, especially in the north, is going to be limited, which is going to result, I guess, in a duplication of billing to OHIP, having to refer south or to the nearest audiologist. Is that the case?

Mr Hood: This committee has already been presented with information in the brief from the Ontario Association

of Speech-Language Pathologists and Audiologists: statistics showing very clearly from the assistive devices program, from the Department of Veterans Affairs and from the Workers' Compensation Board that in fact, in underserved areas of this province, audiology services are more accessible to the public than they are in urban areas. You can get in to see an audiologist more quickly in north-western Ontario than you can in Toronto, due in part to the fact that people like myself have chosen to come here, and because we feel we provide in this area, a more efficient and effective service in audiology than perhaps in Toronto. That is my own personal opinion. But to answer your question, accessibility is very much better in the north than in the Toronto area.

Mrs McLeod: We are running out of time and, in any event, Don, I am not sure that I want to draw you into an area which you did not address in your presentation, although it is one we have talked about, and that is the question of the use of the doctoral term for PhD-trained people in the health field. It may be something you do not want to pursue today.

Mr Hood: After thinking about the issues and discussing this with my colleagues in Toronto, I felt that this particular issue of the holistic approach, of dealing with hearing impairment, was more critical than dealing with the doctoral issue, although that is an equally important one.

The Chair: Thank you very much for your presentation before the committee. If there is anything further at any time, please feel free to communicate with us in writing.

1030

ROGER PATOLA

The Chair: I would now like to call Roger Patola. Welcome to the standing committee on social development. You have 10 minutes for your presentation. We would ask you to leave a couple of minutes for questions at the end.

Mr Patola: I own and operate a ski retail business and I am an avid skier. I am told that the proposed new law would prohibit chiropractors from diagnosing non-spinal joint disorders, and I am here to criticize this as a retrograde step that makes no sense to me. When my chiropractor, Dr Dan Gleeson, asked me to take time to appear before this committee I readily agreed for reasons I now explain.

Although my main sport is skiing, I have played a lot of basketball, football, hockey and racquet sports. Over the years, I have had many injuries from minor joint strains to severe sprains. Like many people I know I started by seeking medical advice, but then found that chiropractors seemed to be able to provide much more detailed diagnosis and effective treatment.

It is obviously going to cut down on freedom of choice in the marketplace if chiropractors are now prohibited from diagnosing joint problems, and the law recognizes medical doctors as the only ones able to do this. This seems to be against the interests of consumers. Changes to the health care system should give more options for effective, less costly treatment, such as chiropractic, rather than requiring referral to the medical profession for diagnosis.

One of my worst injuries was a shoulder separation while skiing about 10 years ago. Conditions were very hard and icy. I flew over the top of a knoll and lost a ski and slammed into what we call a mogul. I separated my shoulder and the pain, let me tell you, was intense. I wanted very thorough investigation and treatment of this problem because I was in the middle of the racing season in Thunder Bay and on the Molson senior circuit and I was building for the North American ski championships at Lake Tahoe.

My previous experience had been that medical doctors could not understand these injuries well or offer effective early treatment. By this time, for various injuries I had been to see Dr Dan Gleeson, a chiropractor here in Thunder Bay, with good results. I saw him, he did a wonderful job and I was back racing—admittedly with the arm in a sling, and gingerly—two days later.

With a problem like this, Dr Gleeson seems to be able to diagnose and treat all the elements, the restriction in the shoulder joint itself and the contributions of all the tendons, ligaments and muscles. He spent a lot of time with me, moving the joint and working all the muscles. Because he got to the source of the problem quickly and treated all the affected tissues extensively, the improvement was dramatic. As I say, I went from excruciating pain to ski racing within two days.

Currently, chiropractors are allowed to diagnose and treat shoulder joints and other non-spinal joints. As a member of the public, I have shopped around and found that a chiropractor can make a more accurate diagnosis than anyone else. I fail to see how it can be in the public interest to pass a law prohibiting this.

I put a little note at the bottom. A medical doctor's eyes are his scalpel. A doctor of chiropractic's eyes are his fingers. Both get results, one with a lot less mess.

I am open to questions.

Mr Beer: I would say to Mr Patola in the first instance that we have had a number of submissions on this point. The Ontario association did present specifically on this matter and it is one I think we recognize that we do need to look at very carefully. I guess the issue, as you put it, is in terms of how we relate consumer choice to protection of the public, and I take it, in your view, in your own experience, you believe that this is an area where as a consumer you should be able to make that choice with respect to a chiropractor.

Mr Patola: Most definitely. There are a lot of athletes around and there are more older athletes around now. They are the ones who need treatment for a lot of sprains and things that we get as we go along. We tend to overuse our body. The medical profession can give you pills and do this and do that, but the chiropractors can go right into the source of the problem, move things around and, doing that, get the blood supply going through that system and make sure that the healing occurs a lot faster than if you have to just be immobilized for a long period of time.

The Chair: Thank you very much for your presentation before the committee.

ONTARIO ASSOCIATION OF SPEECH-LANGUAGE
PATHOLOGISTS AND AUDIOLOGISTS

The Chair: I would like to call now on the Ontario Association of Speech Language Pathologists and Audiologists, Thunder Bay branch.

Please come forward and introduce yourself to the committee. You have 20 minutes for your presentation and we would ask if you would leave a few minutes for questions from members. Welcome. Please begin your presentation now.

Ms Ball: Thank you. My name is Judith Ball. I am here representing OSLA. I will use that term rather than the full name. I thank you very much for this opportunity to appear before you.

Speaking, hearing and understanding are essential skills in today's information-driven and service-based society. People who have a disability which prevents them from communicating normally are isolated from friends, family and colleagues and often from education and employment as well. These disabilities can affect all age groups, from infants to the elderly.

Speech-language pathologists and audiologists are professionals who assess and treat people with speech-language and hearing disabilities. These specialists, working co-operatively with other professionals, provide services through hospitals, schools, rehabilitation centres, government agencies, universities and private practice.

As members of a professional association, OSLA, we welcome the majority of regulations and recommendations set out in the Regulated Health Professions Act and the accompanying Audiology and Speech-Language Pathology Act. There are several key issues, however, which OSLA feels should be more clearly defined or expressed in the legislation to ensure that the public interest is protected.

In general practice today, audiologists and speech-language pathologists assess, diagnose and treat a very specific group of communication disorders and dysfunctions. As a logical extension to this scope of practice, they routinely present conclusions to the patient or the patient's family and counsel them regarding the results of the assessment as part of the assessment process.

OSLA has serious concerns about subsection 26(1) of the Regulated Health Professions Act, and I am not going to read this. It is in my brief and I know you are all very familiar with the wording. As currently written, only physicians and psychologists would be allowed to communicate the conclusion of a hearing or speech-language assessment to the patient. For the patient, this means visits to an audiologist or speech-language pathologist for the assessment, then to a physician or psychologist, who may have minimal knowledge or understanding of the assessment process, for the conclusion, then a return to the audiologist or speech-language pathologist for treatment. This could result in the patient receiving less than completely accurate explanations of assessment results and ultimate confusion regarding the expected course of treatment.

Most important, however, this process will result in unnecessary delays in the start of treatment, delays that have been known to have a negative impact on the rehabilitation process. Early intervention is considered to be essential in

dealing with both hearing and speech-language difficulties. Considering the fact that many of our clients have initial waiting periods for assessment, it is vital that once the initial assessment has taken place the conclusion be communicated immediately to the client or his or her representative and that, where indicated, the rehabilitation process begin immediately.

OSLA believes that in the case of communicative disorders or dysfunctions, assessment and diagnosis are inseparable. Assessment is the process by which the audiologist or speech-language pathologist tests the patient, draws conclusions regarding the disorder or dysfunction and decides the best course of treatment.

1040

In the spirit of the new health care legislation, patients must have the right to discuss their assessments and resulting diagnosis with the professional best trained and most knowledgeable in the area. As the legislation is currently written, it would be impossible for audiologists or speech-language pathologists to discuss with their patients the results of their assessments and diagnosis of their condition.

These restrictions will cause particular hardship for patients in remote communities who must travel significant distances for an assessment by a qualified audiologist or speech-language pathologist. In these cases the client would be unable to complete the assessment, receive the results and immediately begin a course of treatment. Rather, this process may require several visits at considerable cost, time away from work and delays in the initiation of rehabilitation. In the worst scenario, the patient or family may determine that the whole process is too time-consuming, expensive and frustrating and therefore may not seek what may be a service that could dramatically change that individual's quality of life.

In the case of Ontario's native peoples, the services of a speech-language pathologist and/or audiologist may be available either periodically on specific reserves or available in communities within reasonable access. Because of language and cultural differences, these visits are difficult enough and at times lead to confusion and lack of understanding. With the ability to give immediate feedback of assessment results and allay concerns and fears, the speech-language pathologists and audiologists can and have provided a comprehensive, high-quality, user-friendly service. In many of these situations there may be only a once- or twice-yearly visit to the community; therefore, it is vital that following the assessment, where indicated, a course of treatment involving significant support workers in the community be initiated. To date, this is the accepted course of assessment and feedback of results and treatment in native reserves provided by physicians, dentists, optometrists, audiologists and speech-language pathologists. We ask that in the interests of this particular segment of our society the status quo continue.

As often stated, the basic purpose of the act is to set up autonomous self-regulating professions, accountable to the public, and which operate within their areas of expertise. Section 26, as written, undermines the whole foundation on which the legislation is based: the need for a more open, responsive and accountable health care system.

One of the ways in which the act will provide greater public protection is through restriction of titles to the regulated professions. Bill 44, subsection 15(1) restricts the use of the title "speech-language pathologist" and "audiologist" to members of the college. OSLA strongly supports the title restriction in the act, as it provides precise language for the public to distinguish between regulated and unregulated health care providers. For this reason, OSLA believes that it is essential to the protection of the public that the title "speech therapist," which is the historical designation for the profession of speech-language pathology, also be restricted under the act.

Within many settings, including school boards, government agencies and hospitals, "speech therapist" is used as a professional title and a descriptive title in many recruitment ads and job descriptions. Many members of the public, as well as other professionals, continue to use the title "speech therapist" when seeking the services of these professionals. In the past there has been confusion and discussion about the difference between professionals using either the title "speech-language pathologist" or "speech therapist." By not protecting this title under the act, the public might be confused as to whether individuals using this title are qualified and regulated.

As well, protection of this title protects the public from individuals who call themselves speech therapists but who are not qualified in the field of speech-language pathology.

Because of the various resources and different levels of service available to consumers in northern and remote rural communities, we are not looking to restrict or limit these services. We are, however, wanting the public to be aware of and have an understanding of the types of speech-language and hearing services they may access.

In many smaller northern communities, speech and language programming in schools is provided by teachers, with additional courses or professional development in communication disorders. These people are generally referred to as speech-language teachers and speech correctionists. Similar services are provided in preschool programs by infant development and mental health workers.

These services often complement the work done by the speech-language pathologist; however, they are a different level of service and certainly do not replace the assessment and subsequent programming provided by an individual whose specialized training and scope of practice is strictly in the area of communication disorders, that is, the speech-language pathologist/speech therapist. With the act protecting the titles "speech-language pathologist/speech therapist," the consumer will have the option of choosing the desired level of service in an informed manner, with the knowledge that there are variations in the services available and those who provide those services.

Because of the broad range of services provided to the communicatively handicapped across various settings, we believe the legislation should remove the phrase "providing or offering to provide, in Ontario, health care to individuals." Given this narrow wording, consumers seeking these specific services outside of health care facilities would have no protection under this legislation. As stated above, with the growing number of audiologists and speech-language

pathologists employed outside of health care—in schools, Community and Social Services agencies, industry and private practice—we must offer the broadest scope of title protection in order that the consumer is always protected, regardless of the setting in which the service is accessed.

Bill 44, subsection 15(2) reads, "No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as an audiologist or a speech-language pathologist or in a specialty of audiology or speech-language pathology."

This loosely worded section may lead to ambiguity of service available. We would like, therefore, to have a more precise definition of holding out using the following wording: "No person shall take or use any name, title or description implying or calculated to lead people to infer that the person is qualified or recognized by law as an audiologist or speech-language pathologist or speech therapist."

With this definition, in all cases and in all settings, those claiming to be qualified audiologists and speech-language pathologists are exactly that. This will ensure that patients can choose their own form of health care with a clear understanding of the qualifications and professional responsibility of the care giver, first by way of titles used, and second by the way the services are described. As stated in the brief presented to this committee by OSLA in Toronto on August 12, there is ample precedent for more clearly defined legislation as documented in Bill Pr70, passed in June 1990, An Act respecting the Human Resources Professionals Association of Ontario.

I am not going to cover the section that is included in my brief on hearing aids and the scope of audiology. Dr Hood did a fine job of that on his own. So I will come down to my conclusion now.

In conclusion, OSLA supports the introduction of the Regulated Health Professions Act, 1991, as a positive move towards providing the consumer with necessary protection in accessing the professionals working in audiology and speech-language pathology. We strongly encourage the standing committee on social development to consider the concerns expressed above and recommend the necessary changes to the Minister of Health.

We are concerned that with the existing restrictions, especially in the area of diagnosis, many audiologists and speech-language pathologists, most particularly those working in private practice, may feel that the limitations placed on them will force them to relocate to another province. With the existing shortages in these professions already evident in this province, specifically in northern Ontario, we cannot afford a reduction in services. In addition, the extra costs to the health care system both in time and dollars will put a greater strain on health care delivery than ever before.

Thank you. I am open to questions.

Mr J. Wilson: In this part of Ontario, are there a number of people who are holding themselves out as speech-language pathologists or speech therapists who are not necessarily trained sufficiently in those areas?

Ms Ball: I do not believe there are people who actually come out and state that they are speech-language pathologists or speech therapists. People do state that they are offering

speech therapy without appropriate credentials. I am aware of that having happened, as has been conveyed to me by many parents who have accessed services and have indicated to me, "Yes, my child has received speech therapy before." When we discussed where the speech therapy was delivered, it was not actually speech therapy, it was services offering some remedial aspect of speech and language but it was not provided by a speech-language pathologist. So that is where our concern comes in. People do not stand up and say, "I am a speech therapist," but they lead parents to believe that they are offering a comparable service.

Mr Owens: Can you tell me the difference in the academic qualifications around a speech-language pathologist and a speech therapist? Second, while speech therapists will not be regulated, should they themselves also be allowed to communicate an assessment?

Ms Ball: There is no difference in qualifications. That was one of the points I was trying to make: that there is no difference. Historically, our profession started out as being titled "speech therapist." Many British-trained and European-trained people in the area whose qualifications have been recognized in Ontario as being equal to those of a speech-language pathologist have what is termed a licentiate in speech therapy. So they hang a diploma on their wall that calls them speech therapists. Their credentials are identical.

That is why we are looking to regulate that, because I think it could be somewhat confusing to the public. They seek services from somebody who has a diploma that says "speech therapist" as opposed to somebody else who has a diploma that says "speech-language pathologist" when in fact the credentials are essentially the same. That is why we feel it is very important to protect these titles, because the public has a right to realize that these two are the same. There has been confusion through the years with people asking, "Are you a speech-language pathologist? Are you a speech therapist?" and I try to explain that the two are exactly the same.

There is a difference in terms of some of the other terms that are used in the speech and language area, one of those being speech and language teacher or speech correctionist. Those people are essentially teachers who take some extra development in the speech and language area, but they are not trained in speech-language pathology/speech therapy specifically.

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Mr Owens: In terms of extending the right to communicate an assessment, you would draw the line, then, at speech-language pathologist/speech therapist as opposed to extending it further?

Ms Ball: Yes.

Mr Beer: Could you tell us how, in the present circumstance, you would work with a patient around this assessment diagnosis question? I think sometimes it helps us to understand how you do it today versus the concern about what this would mean.

Ms Ball: I operate a small, part-time private practice. In my practice, patients generally come to me because there is a long waiting period in the clinical setting. They come to me because they know they can have an assessment

immediately and can find out immediately if there is a problem, especially when we are dealing with very young preschool children. So in my practice, a parent would come with a child and I would assess the child. Immediately following the assessment, I sit down with the family and discuss my findings and I tell them whether or not I feel there are difficulties. If in fact there are difficulties, we begin to chart a program. We offer parent programs. We cannot slot these people into our parent programs if we cannot tell them there is something wrong with the child. It is a matter of giving immediate feedback and it is part of the entire process.

If things stay the way they are written in the act, I will have to say to parents: "Thank you very much for coming with your child. I will write a report. By the time it gets to my secretary and gets typed, it might be a couple of weeks. It will go to your family physician. By the time you get to see him, it might be a couple of weeks, and that is being lucky. If he or she is able to convey my results as accurately as I would be able to convey them, you might have some idea of what is happening. Then you will have to book another appointment with me, and maybe the whole process, after six months, can get started," as opposed to starting immediately.

Mr Beer: I take it those people come to you, in most cases, on their own or through the school, or would they have been referred by a medical doctor?

Ms Ball: The majority of my private clients are referred by a medical doctor.

Mr Beer: What would you do at the present time following your assessment and discussion with the patient? Would you then send a report or talk over the phone with the doctor again? What is the ongoing link there?

Ms Ball: I send a report. I give a copy of the report to the family. First of all, I give in-person feedback immediately following the assessment report, as much information as I can possibly give the family, as well as some management strategies for them to follow immediately upon leaving my office. I send a report to the physician with an open-ended comment at the end of my letter saying, "If there are any things you would like to discuss about my report, please feel free to contact me." So the physician, in the case of the physician referring, always gets a report. If it is a patient referring himself, then I ask the family, "Would you like me to send a copy to your family physician?" In most cases they do like that to happen.

Mr Beer: So the concern is that, as you read and as your association reads this legislation, you would not be able to do that? I guess what has been said by the government, the previous one and this one, is that there is no intention to limit your ability to make assessments, but you would still see there needs to be a more specific definition of the assessment clause in your own act so that you could communicate that?

Ms Ball: Absolutely. I think otherwise we are just doing half of our job and we are sending people away without the complete assessment being carried out. If I can take it one step further, although audiology is not my area, I work very closely with audiologists. This is very much

the case in an audiology office, where the audiologist assesses, especially when we look at a young child who needs amplification if there is a hearing loss. The way it sits now, when the audiologist does an assessment, if in fact he or she finds a hearing loss, an impression is made immediately so that a hearing aid can be fitted as quickly as possible. This will not be able to happen if the legislation goes through as written, because in order to begin to fit the hearing aid and to take the ear mould impressions, the audiologist would have to convey what he or she has found in a diagnosis, and he or she will be unable to do that. So we feel we are being cut off halfway, that we cannot carry out the complete process in the logical way and the way we have always been doing it.

We are the people who are trained. Physicians are well trained in the area of medicine, but they are not trained in the areas of speech and language development and disorders and hearing disorders and diagnosis of hearing disorders. They certainly do not have the level of training that speech-language pathologists and audiologists have, and I know that physicians with whom I interact make it abundantly clear that they wish me to give the feedback to the families, not themselves.

The Chair: Thank you very much for your presentation. We appreciate your coming before the committee today.

MARY C. MARASCO

The Chair: I would like to call next Mary Marasco. Welcome to the standing committee on social development. You have 10 minutes for your presentation, and if you would leave a couple of minutes for questions from the committee, we would appreciate that.

Ms Marasco: Good morning, Madam Chairman, committee members. My name is Mary Marasco and I am a physical therapist at the rheumatic disease unit at St Joseph's General Hospital here in Thunder Bay. I received my degree of bachelor of science, physical therapy, from the University of Toronto.

I would like to take this opportunity this morning to express my pleasure with the proposed legislation. I am very pleased that physiotherapists have been recognized as primary care givers. I am also very pleased with the suggested amendment to Bill 62, the Physiotherapy Act, that has given us the controlled act of tracheal suctioning, which is something we currently do.

However, there are three major concerns with the proposed legislation. This morning I will only offer you my biggest concern, one that I feel is extremely important to the practice of physical therapy, and that is protection of title. We have two equally valid descriptors: physical therapist and physiotherapist.

In the province of Ontario and throughout Canada, physiotherapists are also recognized as physical therapists. Historically speaking, in Ontario many physiotherapists were foreign-trained. Many came from Britain and used that designation. Throughout the rest of the world, and particularly the United States, the title "physical therapist" is used. Hence the use of both titles here in Ontario.

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Today most Canadian physiotherapists graduate with a degree as physical therapists, like myself. The Drugless Practitioners Act, which is the present legislation governing the practice of physiotherapy, protects both titles. Seven out of nine provinces also recognize and protect physiotherapists and physical therapists.

The cornerstone of the Health Professions Legislation Review when it was enacted in 1982 was to protect the public from harm. This is what I based my thesis on when I graduated. Restricting the use of professional titles was identified by the Schwartz commission as a means of protecting the public from unlicensed, untrained and unethical practitioners who hold themselves out to be something they are not. The present wording of the RHPA, as it stands today, does not protect the title "physical therapist." I believe this will be confusing and misleading to the public and contrary to the fundamental principle of the legislation, which is, to reiterate, to protect the public from harm.

Through my clinical experience and in speaking with my clients, they view physical therapists and physiotherapists as the same thing, with equal training, education and competency. Many other health care professionals with whom I work also recognize the two terms as synonymous. The potential here for harm exists when the public seeking physiotherapy tries to distinguish between a regulated, licensed physiotherapist from an unregulated, unlicensed and possibly unqualified individual holding himself out to be a physical therapist.

As a concerned physical therapist, I believe that in order to protect the consumer, prevent confusion and be consistent with the present legislation, as we are regulated now, the two titles, "physiotherapist" and "physical therapist," should be protected titles. My recommendation to the standing committee is to amend Bill 62, the Physiotherapy Act, to include "or physical therapists" wherever "physiotherapist" occurs.

If you have any questions, I am open to them.

The Chair: Thank you very much for your presentation. A question, Mr Beer?

Mr Beer: On the issue of speech therapy, I wonder if I could direct a question to the parliamentary assistant. In the discussion in Schwartz, did he set out a specific reason why he felt that the speech therapy—

Mr Wessinger: Physical.

Mr Beer: Sorry, physical—I am getting confused this morning—but why that term should not be protected? We have had this raised now on countless occasions. What was the reason?

Mr Wessinger: I will ask ministry staff to respond to that.

Ms Bohnen: Alan Schwartz, in the review, felt the public was best served by having a minimal number of well recognized, well protected titles used—protected and used to identify members of the profession. For each profession, the review determined which title was that title. For this profession the review determined that "physiotherapist" was the title by which most people in Ontario identify members of the profession and that the terms "physical therapist" and "physical therapy" were more generic, but

that people in Ontario really recognize their practitioners as physios.

Mr Beer: One follow-up question, then. In your own work, how do you refer to yourself and what do most of your colleagues call you, when they are being nice?

Ms Marasco: I refer to myself a physical therapist, because that is what I graduated with. Commonly, in the health care setting, we are termed "physiotherapy," but that is inconsistent and we go by both.

The Chair: Thank you very much for your presentation before the committee today. If, in the course of these hearings, there is anything further that you would like to communicate, please do so in writing. Thank you very much.

ONTARIO SOCIETY OF OCCUPATIONAL THERAPISTS

The Chair: I would like to call next the Ontario Society of Occupational Therapists, region one. Please introduce yourself to the committee. You have 20 minutes for your presentation and we would ask you to leave a few minutes for questions by the committee.

Mr McHugh: On behalf of the Ontario Society of Occupational Therapists, region one, welcome to Thunder Bay. My name is Tom McHugh, and I am an occupational therapist working in the field of mental health at the Lakehead Psychiatric Hospital. I am also a director of the Ontario Society of Occupational Therapists which represents Ontario's 2,300 occupational therapists. As director for region one, I represent therapists practising from Marathon in the east, all the way west to the Manitoba boundary. I have four goals for the time that I spend with you today: first, to tell you something about my profession; second, to communicate our response to the proposed Regulated Health Professions Act; third, to point out two small problems, largely problems of language that we fear may limit our current scope of practice; and finally, to answer any questions that you raise.

You will find all of my points outlined for you on the three photocopied sheets that I have provided for you. First, my profession: Occupational therapists believe that human beings have a need to be purposefully engaged in meaningful activity in order to be well and whole. Using purposeful activity as a treatment, occupational therapists work to prevent disability and to promote, maintain or restore wellbeing and function in three broad areas: self-care, leisure and productivity. We follow a process of assessment, program planning, treatment, discharge, follow-up and program evaluation in the treatment of clients.

For example, it is the occupational therapist who will assess the living skills of a person who suffers a stroke, work to maximize these skills through daily treatment sessions, make recommendations on adaptations in the home, or oversee the prescription and purchase of a wheelchair. In treating a person with chronic schizophrenia, the occupational therapist might focus on developing such essential skills as budgeting, using public transit, cooking a simple meal, or doing laundry. We work to give people of all ages and capabilities control over their own lives.

Bill 43, the omnibus bill, and Bill 58, the act to regulate occupational therapists, are, we feel, an important

acknowledgement of the important role that occupational therapists play in the delivery of health care in the province, and an excellent means to enhance public protection in health care. Legislation has been the dream of the Ontario Society of Occupational Therapists for 20 years. We are delighted to have this opportunity to communicate our support for the thrust and principle of the proposed Regulated Health Professions Act.

I would like to point out, however, on behalf of the society, two concerns about specific components of the act. In Bill 43, paragraph 26(2)(1), it is stated that only those professions allowed the controlled act of diagnosis or assessment may communicate a conclusion identifying a disease, disorder, or dysfunction as the cause of symptoms of the individual. The controlled acts of diagnosis or assessment are not present in our act. This poses a problem for us. It may mean that the communication of the results of our assessment would have to be done by the doctor. I think that Mr Gilbert has given an excellent example of how this limits current practice as it relates to a child with fragile X syndrome. Let me give you another example.

If your parent is admitted to hospital with a stroke, the doctor may communicate that to you, but what does that mean to you? It may mean partial or whole paralysis of one side of the body. It may mean visual neglect of one side of the body or environment. It may mean spasticity in the hand or arm, or even depression. It will require skilled assessment by a number of professionals, occupational therapists among them, to identify these symptoms.

Our current practice would be to communicate these symptoms to the patient and the family, and help them cope with the impact that they will have on daily living. No provision for these activities is contained in the act. We propose that a paragraph be added to subsection 26(2) which identifies that a person regulated under the Regulated Health Professions Act not be in contravention of this section when performing assessments that are within the scope of their practice, including the formulation of assessment conclusions, and the communication of such to clients.

Finally, the title "occupational therapist" is only protected in the provision of health care. Occupational therapists practise in a broad range of settings which may not be identified as health care. For example, occupational therapists may practise in the school system and in the manufacturing and insurance industries. We feel that subsection 14(1) of the act to regulate occupational therapy should not stipulate title protection in the provision of health care only, but across the diverse settings in which OTs practise. As well, the society suggests the strengthening of the holding out clause, Bill 58 subsection 14(2). This amendment would prevent individuals from misrepresenting themselves as occupational therapists, or from implying that they are qualified to practise occupational therapy.

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To sum up, the society strongly supports the proposed acts. We do have some recommendations to make in the wording of Bill 43, as it pertains to diagnosis, and in the wording of Bill 58, as it pertains to title protection and holding out. You will find our positions regarding diagnosis, title protection, and holding out outlined on the sheet entitled

"Position Statement." More important, you will find proposals for specific amendments on the sheet entitled "Proposed Amendments." Thank you for your attention today. I will try to answer any questions that you may have.

Mrs McLeod: Thank you for the presentation. I was interested in the recommendation that you have made about an addition to the diagnosis clause. One of the issues that I think the committee has been looking at to deal with the question of assessment and communication for those who are regulated under the act, is whether or not a definition of assessment, which allows for that communication, would be of assistance. But you seem to have added a component that would ensure that the diagnosis clause would not override that kind of definition. I gather that your association feels it is important, that you not just define assessment but make sure the diagnosis clause would not override the definition?

Mr McHugh: That is right. I can just speak personally. I think that for a long time the occupational therapists' society has been talking about diagnosis, and I really wondered what the fuss was about. But when it is read in the act it really does limit our current scope of practice. I do not want to be the person who tells a patient that they have had a stroke. That is certainly in the ongoing treatment that I am going to provide after that. I want to be able to freely discuss what stroke means to that individual.

The Chair: Thank you very much, it was an excellent presentation and we appreciate your coming before us today.

RUPERT FLATT

The Chair: I would like to call next, Rupert Flatt. Welcome to the standing committee on social development. You have 10 minutes for your presentation. We would ask you to leave a few minutes for questions at the end.

Mr Flatt: Ladies and gentlemen of the committee, my presentation is brief, pertaining directly to subsection 26(2) of Bill 43. The inference of a prohibition of the giving of information in response to a question asked by a patient of a practitioner is not only confining but frustrating. I personally have an interest in any information pertaining to my wellbeing, or my family's, and I expect questions to be answered when they are in the realm of the practitioner's knowledge and training. I do not know how practitioners can operate effectively without asking questions themselves of the patient, and the practitioner will receive questions in return, such as "Why would you want to know that?" or "Why does it feel this way?" or "Why are you doing that?"

I have had a great deal of experience with practitioners over the years, being born with a harelip and cleft palate. I have had speech therapy, and now have problems with hearing. I now wear a hearing aid. I want to understand the function of my hearing aid, and I have asked questions of the person testing and fitting my aid. I must say that the questions were answered to my satisfaction. I do not believe that my medical doctor has the time, expertise, or desire to answer my questions about my hearing problems other than in a general way.

There is often a problem with getting an appointment quickly with my doctor for non-emergency problems. The

recommended specialist has a six-month backlog. Unnecessary worry and concern can be created if a practitioner says something to the effect that he or she is going to call your doctor about something that they noticed but without discussing it with you; or they are not prepared to discuss what they think it is. It could be a condition that the patient is fully aware of and being treated for at the present. The loss of time and the creation of anxiety is counterproductive.

In conclusion, I think that controlling information dissemination by a practitioner is not only a frustrating practice, but it can cause unnecessary concern and worry. I thank you for your attention and I will answer any questions that you might have.

Mr Beer: Thank you very much for your presentation. I think it is useful for the committee to have a personal perspective in terms of your own relationship with a professional. I guess we still have to grapple with the question of whether the person providing the information indeed has the expertise or the knowledge and is the one who ought to be doing that. The difficulty is finding a way of both protecting the public and ensuring that you can exercise your choice as a thoughtful consumer in getting assistance from that person.

Is it your sense as a consumer that, where the committee has that issue before it, we should err on the side of the consumer choice as opposed to the public protection, or what our sense might be of a stricter public protection? Where do we find the balance, where do we draw the line there?

Mr Flatt: I can only answer from my own experience that those practitioners I have dealt with—chiropractors, ear specialists, this sort of thing—have answered my questions very much to my satisfaction. Only once did the scenario happen in my life where a chiropractor noticed something that he did not think was right. He triggered my curiosity by taking my blood pressure, something he probably should not have done, but he questioned it. He did not say anything to me. He would not tell me what he found. He said: "You go and see your doctor this afternoon. I am phoning him now." My doctor saw me that afternoon and it resulted in getting the situation corrected over the next brief period of time.

The fact he took my blood pressure indicated to me what he thought was wrong. I have known the man since I was a child, so our relationship was very good, but he would not disseminate the information, nor should he have in my opinion. I agree with what you are saying.

However, generally I find that the present practice of dissemination of information is satisfactory. I think to curtail it is what I am speaking of. To make it more difficult to get information than it is now is counterproductive. Thank you.

Mr Hope: How did you know the service that you were getting was accredited service and was going to help you? As you look at the broad consumer groups out there or the services that are offered, how did you know you were getting the best service?

Mr Flatt: I went to my doctor and said, "I am having a hearing problem." He said: "I am going to send you to this man who will test your hearing and examine you. He is a specialist." Five months later I went to see this specialist.

He examined me thoroughly and had me tested for hearing. After the test we discussed my problem and decided it was too early for a hearing aid. However, he gave me the names of three different locations which he recommended for a hearing aid. I ended up going there eventually when I needed a hearing aid, when I felt the problem was severe enough and where I got what I felt was excellent help and direction. I now have a hearing aid which works very well.

Mr Hope: You made reference to other services that you were provided. You said you had some questions that you had answered? What were some of those questions, like rehabilitation, or was it just a matter of hearing something?

Mr Flatt: No, I would ask him, for example, when he was examining my ear—I have psoriasis in my ears, a little bit of it—if he knew of something that might help clear it up. I had also asked the doctor, the specialist, and he said, “It is a condition that some people have, and I do not think there is anything that works on it particularly.” I have since found a product from a skin specialist that works on it quite nicely. But the point is that I do not think his answering, “Yes, I think there is a product; maybe you should see your doctor about it,” would have been wrong at that time, had I asked him that question. I did not, but I could have.

With things of that nature, I think the practitioner uses discretion as to what he will answer and what he will not. But I do not think that he should be muzzled to the point where he cannot say why he will not answer. If I am with a hearing specialist, “I am not a skin specialist, and that is a skin problem I think you should see a skin specialist about,” is a satisfactory answer to me.

The Chair: Thank you very much for your presentation. We appreciate you appearing before the committee today.

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KATE FARMER AND ALAN CRANTON

The Chair: I would like to call next the Ontario Naturopathic Association, Thunder Bay chapter. Welcome to the standing committee on social development. Please introduce yourselves. You have 20 minutes for your presentation, and we would ask that you leave a few minutes for questions from committee members.

Ms Farmer: My name is Kate Farmer, and I am a naturopathic patient and not a member of the association.

The Chair: Are you here representing the Ontario Naturopathic Association?

Ms Farmer: Yes, but I am a patient. I was asked by Alan Cranton to make a presentation as a patient.

The Chair: Thank you.

Ms Farmer: Naturopathic medicine is very important to myself, my family and many other people I know of, and it is an approach that I value because it considers all aspects of my health and it is a holistic approach. This does not mean that it does not work with traditional MD medicine. In fact, I find that all of these approaches interact for my own health care. There are times when my naturopath has referred me to an MD in situations where that was more appropriate, and I appreciate that.

From what I can understand of this bill, and I have not spent a lot of time with it, this has been rather short notice for me, I feel that those in naturopathic medicine should be able to have the full scope and use of all the training that they receive. I am very glad that it is regulated because I like to know that the title goes with the education that it represents. I find it a safe, dependable and cost-effective form of health care, and usually I have between one and three visits for any given problem, much the same as I would if I went to an MD.

My main comment is I would like to make sure that no limitations are placed on the kinds of modalities that a naturopath is now able to use in Ontario, because I think that we have a very good broad-spectrum approach to health care, and I appreciate that.

Mr J. Wilson: I was just wondering, Ms Farmer, what are some of the modalities that a naturopath would use now? I am not familiar with the profession at all.

Ms Farmer: The first thing that comes to my mind is the much more thorough questioning technique when I go in there with a specific complaint or a problem. Say I have a headache, the questioning that goes with this involves there been changes in diet, changes in your environment, what is going on in your life, as well as the physical kinds of questions that I would receive from an MD. The kinds of modalities I have experienced deal with botanical kinds of medications. I am not sure “medications” is the right word, but they are botanical treatments.

Mr J. Wilson: I know what you mean.

Ms Farmer: There are some forms of gentle manipulation. I believe that X-rays are included. It is a non-intrusive method. It would be my first line of defence for what is going on with me. I have not got a list of exactly what all the modalities are, but I know that the interrelationship of them seems much more extensive and comprehensive than most of the other specialists I have seen.

Mr J. Wilson: I appreciate that, because it does give a general sense of what they do. Various people have tried to explain this to me. I think I am going to go visit one some day, and then I will get a firsthand view of it.

Ms Farmer: That is probably the best way.

The Chair: Mr Owens.

Mr Owens: Where do you draw the line personally between where your naturopath leaves off and where the physician picks up?

Ms Farmer: I do that in conjunction with my naturopath. I do not make that decision by myself, although I would in terms of a broken bone, a car accident, go right to the emergency room. I know that is the appropriate place for me to get bones set and things sewn up and so forth.

I had one specific health problem that I did not know where it was leading or what was going on, and for this problem after speaking with my naturopath he referred me back to an internist. Some tests were run in the hospital setting, which were very appropriate. So I have a great deal of confidence that when a problem needs to have allopathic attention my naturopath will tell me this is the time to go into the regular medical system. So I have not

had any problem with that because there has been a good deal of give and take as well as overlap.

The Chair: I believe there is a presentation also from Mr Cranton.

Mr Cranton: I am Alan Cranton and I practise in Thunder Bay. I am a naturopath. I graduated from the Ontario College of Naturopathic Medicine with a doctor of naturopathy degree. I practise full-time in Thunder Bay. I was born and grew up in Thunder Bay and I came back to practise. Thunder Bay is different to southern Ontario, the big city. The fact that because of the time and distance from the city I do not really stay up to date on politics and what is going on down there, I have to be quite self-sufficient up here, working by myself.

The reason I am here to testify is to basically let you know how I feel. I want to see naturopathic medicine continue as it has been practised in Ontario without having any of the modalities modified or eliminated.

I understand that the profession needs to apply to be part of the new legislation, but I do not want to lose anything as that process is going on. I feel it is important to bring the skills that I have been trained with, to bring them together to work in the patient's best interest. For instance, a patient comes to see me about a particular health problem. After a consultation and a physical examination a diagnosis is made and I determine that I am going to use two or three different modalities on him—manual medicine, botanical medicine, or herbs, and for instance homeopathy. If that individual went to one practitioner to have the spine adjusted, went to another practitioner to have the herbal medicine applied, and went to a third person to have homeopathy prescribed, he would not get the full scope and it would not get the whole approach done to them. It is along those points that I really want to see the scope of naturopathy continued in Ontario.

I see that naturopathy is a very safe and cost-effective means of health care, and part of the definition for me is preventative. It is important to me that you understand that my approach is not available from anybody else, so that if part of the modalities are taken away from my opportunity to practise, there is nobody else that patients such as Kate can go to to receive that type of care.

I work with the medical profession. I see myself as part of the health care team in Ontario. I accept referrals from medical doctors for my type of care, and I also refer patients to general practitioners and specialists.

1130

Mr Jackson: Alan, I was pleased when you made the reference at the end of your presentation to working with physicians, and having used naturopathy myself and having worked with three different doctors over the course of my adult life, I want to focus on this issue of acceptance and the working relationship that you have within the medical community. Because, as a consumer, and certainly Katharine will identify with this, the system works best when there is an understanding and an ability to work with the groups interchangeably, whether it is—I mean, 50 years ago chiropractors in this province were in the position you are in today. So one must not completely have a

closed mind to these concepts. But within the medical community there is not nearly the acceptance level.

Can you talk a little bit more about that, because I find there is a growing trend in the medical profession of acceptance which has not been really talked about very much in the committee setting.

Mr Cranton: I can only speak from my personal experience. I cannot speak for the rest of the province or other naturopaths or for the association. But my experience in Thunder Bay is that I have been quite well received by the medical practitioners that I work well and closely with.

My practice has been growing since graduating and opening up as a naturopath, and I expect it to continue growing. I guess my future goal in the next four to five years is to open up a multidiscipline clinic where we are all under one roof—dentists, optometrists, chiropractors, naturopaths, medical doctors, and so on. That is a dream that I hope to bring to reality.

In Thunder Bay, a lot of understanding has to be raised between the different professions, and it is up to me to bring that education to the other medical practitioners. It is something—because my practice has been busy I have not taken those steps to try to educate the other people. I am quite busy as I am.

Mr Beer: With respect to the discussions that were held around self-regulation for the naturopaths earlier, what concerns do you have in terms of those modalities that you might not be able to practise? Are there some specific things that you are concerned about, or is it just your sense of the unknown in terms of how the advisory council is going to deal with your profession?

Mr Cranton: Speaking personally, I feel it is more of a fear of the unknown, not knowing exactly what they want to regulate, what they want to remove.

Mr Beer: So it is not anything specific that, say, chiropractors may be able to do that you cannot do or doctors. The sense is simply that you are going to be limited if you are self-regulated?

Mr Cranton: Right. I feel that I am quite well trained and skilled at performing what I was trained in at the naturopathic college. If any of those modalities were taken away or limited, then that would have a dramatic effect on how I use those skills to help my patients.

Mr Owens: I am trying to get a handle again on the naturopath, like my colleague Mr Wilson.

Do you see your role as more of a preventative role? You have used that language in your presentation—more of a preventative role rather than a curative role?

I guess along with my question to your co-presenter, I have a concern if a patient presents to you with a headache, how long do you deal with that patient before you refer to a physician? A headache, as you are probably well aware, can mask other problems.

Mr Cranton: You have asked me about two or three questions.

Mr Owens: Right.

Mr Cranton: Which one would you like me to—

Mr Owens: All three of them. Start with preventative versus curative.

Mr Cranton: I believe that they work hand-in-hand. There are certain patients who will be referred to me or they refer themselves to me once they have got a condition, in which case I am working at a curative role. Other patients will come to see me saying: "I don't have a problem. I don't want to have a problem. I have got a history of such-and-such in my family. What can we do now?" So that is where it works more along a preventative role. I do not see a separation. I think that when I work with a patient, I work on all levels, preventative and curative.

Mr Owens: In terms of how long you deal with a patient with a specific problem, again using the headache as an example, at what point would you say, "Okay, Mr—or Mrs—Jones, I think it is time for you to see a physician, an MD"?

Mr Cranton: Personally, again this is not the association answering, but if there are hard neurological signs that I do not deal with, that are not within my scope of practice, I phone up their practitioner and say, "Would you take Mrs Jones in this afternoon?" and I may explain to the patient: "Look, you've got loss of vision in part of your eye which could represent some pressure on a cranial nerve. Let's get you in and get some further checks done."

Mr Owens: So your referral practices, then, would be more individual, patient-specific, rather than having a general rule of, I deal with a headache for one week and then refer if it does not—

Mr Cranton: I do not have a cookbook practice, if that is what you are implying. No, every individual patient, and every individual case for that patient, is taken on a one-on-one basis.

Mr Jackson: I would like to explore what pressures there are for you for the purposes of upgrading. Naturopathy has some new innovations. The one I am familiar with recently is a blood-measuring instrument which looks at the pH level and it is very refined equipment but it also involves the drawing off of blood and the testing, and then naturopathy programs designed around balancing off that level.

My understanding is there is a lot of technical work involved in upgrading. What governs your practice in order to move you to take those kinds of courses and certifications so that you are not setting out that you are qualified to perform some of these more technical—I mean, the computer age has caught up with naturopathy, as you know, and there are some technical things that are required in that. It is not all herbs and manipulations.

Mr Cranton: Right.

Mr Jackson: What causes you to make those upgrades, and tying that to setting out certain procedures and practices that you might perform, or are you self-governed in that context currently?

Mr Cranton: I would have to refer you to my assistant, who is in the wings. Dan? I cannot answer that question.

The Chair: Would you like to come forward and take a seat before the microphone for Hansard? Please introduce yourself.

Mr Labriola: Thank you. I did not expect to be speaking today. I am Dan Labriola. I am with the Ontario Naturopathic Association. I have addressed you earlier.

In terms of upgrading and additional training, there is a continuing education, and hopefully a continuing competency, requirement that will be included once we are part of the new regulation. At that time, we expect that your question would be fully answered. In the interim, I think our practitioners are like most practitioners in that there is such a wide variety of modalities and equipment and resources out there, a practitioner is required to be certain that he or she has the skill, the knowledge, the equipment and the background to do the particular things he wants to do. Once again, you are addressing a very pertinent point. There is more technology out there than any one individual can learn, whether it is medicine, naturopathy or whatever. So at this point, the practitioner is individually responsible to be certain that he or she is in fact performing a responsible job, doing whatever that is. If that is not done, then that would be contrary to competent practice.

The Chair: Thank you very much for your presentation before the committee. We appreciate your appearance today and we know that if there is any additional information that you feel the committee should have, you will communicate with us in writing.

NORTH OF SUPERIOR COMMUNITY MENTAL HEALTH PROGRAM

The Chair: I would like to call now the North of Superior Community Mental Health Program. Introduce yourself to the committee. You have 20 minutes for your presentation.

Ms Lane: My name is Sally Lane. I am the executive director of the North of Superior Community Health Program. On behalf of our consumers and corporation, I must express my concern over the impending third reading of Bill 43, the Regulated Health Professions Act.

Our agency provides community mental health services and substance abuse and referral services, both funded by the Ministry of Health. We are situated in the rural portion of Thunder Bay district—that is, to the east of the city—covering a geographical area of 81,000 square kilometres. We include 10 organized municipalities, unorganized areas and Indian reserves and communities. We have no psychiatrists or registered psychologists resident in our area. We are the only agency available for mental health counselling for non-first-nation clients and one of two agencies offering services to first-nation clients. Our catchment area also includes five municipalities which are designed bilingual under the French Language Services Act and to which we provide francophone services, to the best of our ability.

The agency staff is mainly composed of social workers—masters of social work or honours bachelors of social work—with some bachelors of arts and masters of arts psychology graduates. Under the proposed legislation our workers would not be entitled to registration in the proposed college of psychology and thus during their legitimate work could be liable for prosecution under paragraph 26(2)1 of the proposed act. This paragraph is the "diagnosis" reference

which states that unregulated workers are prohibited from communicating "a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms."

As our workers routinely, in the case of psychosocial problems, have to draw conclusions and communicate these conclusions, we would be leaving ourselves, in our opinion, open for prosecution by clients and/or the college of psychology. We do not medically diagnose and have no wish to do so. This is handled by our visiting psychiatrists. However, psychosocial problems can be assessed and treated by our counsellors without referral to the visiting psychiatrists.

The demand for our services is considerable. In 1990-91 my agency saw 866 clients. These people could be faced with very limited or no services if paragraph 26(2)1 were to continue in its present form. Revision of the paragraph should permit counselling and non-medical communication in the mental health field.

Thank you for your attention to this matter. The second two pages of my presentation are just maps to give you some indication of what we cover.

The Chair: Thank you very much for a very thoughtful presentation before the committee. All members have received your written communication. If in the course of our hearings there is anything further you would like to communicate with us, you can of course continue to do so in writing.

Mr J. Wilson: I am curious about the last paragraph on the first page, where you say your BA or MA psychology graduate would not be entitled to registration in the proposed college of psychology. Is it your understanding that entry would be dependent upon a doctorate?

Ms Lane: It is the doctorate level.

Mr J. Wilson: Can I get a clarification from ministry staff on that, from the parliamentary assistant?

Mr Wessinger: Yes, that is correct. You have to have a doctorate degree in order to be registered as a psychologist under the act.

Mr J. Wilson: That is a standard set forth by the college itself?

Ms Bohnen: If I could just speak to that, the psychologists, as you know, are currently regulated under the Psychologists Registration Act. Under that act, they require a doctorate to be registered. One of the first tasks of the council of the new college of psychologists will be to determine the requirements for registration as a psychologist with the new college. The Ontario Psychological Association and the Ontario Board of Examiners in Psychology certainly support retention of the doctorate as the qualification. Other groups representing the non-PhDs are very anxious to see a way in which BAs and MAs could qualify for registration. It is an issue that will have to be dealt with in the future.

Mr J. Wilson: You are the first one to bring that up, although I have had seven groups of the non-PhDs in my office. I am curious it did not come up before now in our committee hearings.

Mrs McLeod: I also want to address the question of the BA or MA psychology graduates. I do think that this is one of the issues which is probably less concerned with the diagnosis clause and more concerned with decisions about entry into the college and ability to practise. I wanted to ask about the current situation in the north of Superior area, Sally, where you do have BA and MA people trained in psychology practising. Is there nominal supervision provided now? Perhaps you could just say a word about the difficulty of providing for supervision in those fields.

Ms Lane: We do not have any registered psychologists resident in our area. Neither am I funded for a registered psychologist. I am funded for visiting psychiatrists. These do provide the clinical supervision. The psychology graduates are approximately a quarter of my staff. The rest of my staff are either HBSWs or MSWs, which would never fall under, according to the proposal, the college of psychology. At the present moment, they are unregulated workers. We do not have any direct psychological supervision, no.

The Chair: Thank you very much for your presentation before the committee today. That is the end of the presentations for this morning's session.

The committee recessed at 1145.

AFTERNOON SITTING

The committee resumed at 1400.

NORTHWESTERN ONTARIO
CHIROPRACTIC SOCIETY

The Chair: The standing committee on social development is now in session. I would like to call the first presenters for the afternoon, the Northwestern Ontario Chiropractic Society. Would you come forward, please, and introduce yourselves to the committee. You have 20 minutes for your presentation. We would ask that you leave some time for questions from committee members. Please have a seat and begin your presentation now.

Dr Schroeder: I am Dr Brian Schroeder. I am the president of the Northwestern Ontario Chiropractic Society. I graduated from the Canadian Memorial Chiropractic College in Toronto in 1988 and have been in practice in Thunder Bay for the past three years. There are approximately 25 chiropractors in Thunder Bay and about another 10 in surrounding regions such as Nipigon, Manitouwadge, etc.

The NWOCs is a regional society and is associated with and an extension of the Ontario Chiropractic Association. We provide representation for the profession at the regional level.

I would like to thank the committee for allowing us to make a presentation at these hearings, as I understand that the basic thrust is to get feedback from the public rather than the professions. We could have brought our professional concerns to you today as part of our submission, and I must say there are those of us here in the north who are quite concerned over the possible loss of such an integral part of our professional scope. Frankly, we cannot quite see how the Ontario Chiropractic Association has allowed it to come to this. Diagnosis and treatment of non-spinal joints is such a fundamental part of our day-to-day practice that we cannot imagine it being taken away. However, much as we appreciate the opportunity to make such a submission, we have chosen instead to put our energies into co-ordinating patients making presentations, as we realize this is what you are really looking for—input from the health care consumers.

So for our society's presentation we would like to give you something I do not believe you have had a chance to do, have a patient come up and make her submission and have the patient's chiropractor present to answer any possible questions you might have of a technical nature that the patient might not be able to fully answer. As such, I would like to introduce a patient of mine, Ms Melanie Trognitz, and she is going to make a presentation.

Ms Trognitz: I dance with the International Academy of Ballet and Dance in Thunder Bay and I have danced since the age of approximately three. I hope to either have a career in performance, teaching or choreography.

Early last year I was running in a relay race and strained my left ankle and the next day during dance practice I further injured the ankle when I fell over when I went up on point. There was a lot of discomfort and pain. This was of great concern to me since I was preparing for

a dance competition during the Lakehead festival, which was in approximately three weeks' time.

My uncle Irv, who is a medical doctor, recommended to my mother and me that I see a chiropractor because they understood this sort of problem well and could probably provide the most effective treatment. As a result I saw Dr Brian Schroeder, a local chiropractor. He examined my ankle and also my left leg and hip. He did a number of flexibility tests which showed the difference in the strengths and tendons of the muscle groups in my left and right legs.

I saw him several times over a period of approximately two to three weeks and he used the ultrasound, which manipulated my ankle and my hip, and used massage techniques on my tight muscles in my left calf. Immediately I could point harder without pain. My recovery was so good that I was able to compete in the dance festival, which neither I nor anyone in my family thought would be possible. This was particularly important to me because I was involved in some group numbers.

I understood there was some question whether chiropractors could have a detailed understanding in ankle joint problems such as mine. My experience from this, my first visit to the chiropractor, is that they do.

Mr Hope: I have just a number of concerns. As you refer to a local family member who is a doctor, a cousin who is a doctor, if you would not have had advice, would you have seen a chiropractor and, if so, do you think it is going to help, especially what you are trying to achieve in your life as a performer, teacher and a choreographer? Do you think the methods a chiropractor shows you will eliminate the possibilities down the road?

Ms Trognitz: I know people who have been to chiropractors, not for similar problems, but for ankle sprains and strains, and it helped me and I did not think I would be able to go in—it hurt to walk on. I ended up doing a group number on point. I did not end up going in the festival for the solo number because I had not had enough time to prepare for it, because it was just prior to the competition. What was the other part of the question, about my—

Mr Hope: If you did not have the referral.

Ms Trognitz: If I did not have the referral, I am not sure. I do not know if I would have ended up going in the festival, but I think I would have ended up seeing the chiropractor anyway, because my dance teacher—I take lessons from two dance schools, the International Academy, which is basically ballet. I take ballet from there and I also take tap and jazz from Fay Steadwell, Fay Gleeson Dance Centre, and she also recommended I see someone at the clinic.

The Chair: Thank you very much for your presentation. We appreciate your coming before the committee today. Anyone is welcome to submit in writing any further information you think might be helpful for the committee during its deliberations. Thank you very much for coming today.

We have had a cancellation, the Equay-Wuk women's group.

YVONNE SLIVINSKI

The Chair: Is Yvonne Slivinski here? Please come forward now. Welcome to the standing committee on social development. You have 10 minutes for your presentation. All members of committee have received your written submission. Please just relax and tell the committee how you are feeling about things. We are here to listen to you. We would ask you to leave a few minutes at the end for some questions from the committee members.

Mrs Slivinski: My name is Yvonne Slivinski and I am a concerned consumer. There are certain things I have come to expect when I use the services of any professional, whether it be a doctor, dentist, optometrist or, specifically here today, a dental hygienist. I should be allowed as a consumer to make some intelligent decisions and choices about my oral treatment that should be based on the advice of my chosen dental hygienist.

It is my understanding that dental hygienists are not allowed a vote on issues concerning their profession and that their regulatory body consists mainly of dentists. Is this type of structure for a regulatory body realistic and progressive thinking? In the 1990s surely the status quo is an unacceptable alternative for dental hygiene. This legislation is a beginning.

My presentation will focus on my choices as an oral health services consumer. My perception that my choices are limited disturbs me. I want to have the option of choosing my own dental hygienist. I may not want the dental hygienist the dentist employs. Would I jeopardize my health by choosing a hygienist other than the one employed by the dentist?

I want to establish a rapport with my dental hygienist, just as I do with my doctor and dentist, etc; one that maintains a professional relationship based on trust, quality of service and follow-up. I want to feel confident that my dental hygienist is going to completely scale, polish and apply fluoride to my teeth with full knowledge of proper procedure and pride in performance. I feel sure my dental hygienist is totally aware of any complications that may transpire during a session and would be capable of handling them, should they occur. A dental hygienist has learned professional skills.

Who makes the decision as to the length of time it will take to properly clean my teeth? I would like to think it is the hygienist. Is the dentist well enough informed regarding dental hygiene procedures to effectively judge the quality of treatment? Why is it necessary for the dentist to oversee the hygienist's work? Is it fair to take away their professionalism and pride in performance to accommodate the employer's perception of what is required to maintain good oral hygiene?

In 20 years any one of us might be placed in a chronic care institution. I want to know that a dental hygienist will be available to continue to maintain my oral health with preventive care. It is my understanding that presently dental hygienists cannot work in these facilities because of the supervisory restrictions, that a licensed dentist must be present while a hygienist delivers his or her services. We need to remove this archaic thinking.

We all know that continuing good oral hygiene is imperative to the quality of our existence, not only for health reasons but because it has a great impact on our sense of wellbeing. The existing supervisory restrictions totally ignore not only the needs of the elderly but also those people who are institutionalized for any length of time in nursing homes, homes for the physically handicapped, mentally disabled, prisons and detention centres. Is access to oral hygiene limited to only those physically and mentally fit? Do we not need a clarification and revision of supervisory restrictions?

Access to the complaints process of the college is a concern to me. I want to be able to ask questions. Presently, the process is not user-friendly. I do not know how to tap the system.

When I visit a dental office I make the assumption that I will be provided with sterile surroundings, sterile instruments, ethical treatment and a professional who will ensure my medical history is updated. I am happy to see this area is being addressed in the new act.

I submit that hygienists should be policed by a committee comprised of their own peers and consumers. They should be allowed to proceed in the professional manner which is taught them during their formal education. Presently they are restricted, depending on the respect and commitment their employer has to their profession.

1410

With this piece of legislation I can feel comfortable that the onus will be on the hygienists to ensure that all standards of their profession are adhered to. As a consumer of dental hygiene with concerns and expectations, I feel it is my duty to have a voice here in the process today. Let me have the option of choosing my own dental hygienist, based on the knowledge that they are a self-regulated group able to carry on learned techniques that are required for proper, professional procedures. I need to know that if a member of my family or myself should have to spend time in a long-term facility, the present supervisory restrictions be replaced with a more realistic approach to dental hygiene for the vulnerable. Let the process be user-friendly. As a consumer of dental hygiene services, I feel comfortable knowing that dental hygienists will be regulating themselves and accountable to the public.

Mr Beer: Thank you for the perspective of a consumer. We want to get that perspective as we go through our hearings and welcome that particular look. I wanted to clarify the question of the council, perhaps through the parliamentary assistant, with respect to the statement around the nature of the council and who is going to be sitting on it. Is it essentially dentists who are on that regulatory council?

Mr Wessenger: I will refer this to the counsel for the ministry.

Ms Bohnen: Currently, dental hygienists are licensed by the Royal College of Dental Surgeons of Ontario, but they only sit on the council of that college as observers, they cannot vote. Under the new legislation, dental hygienists would have their own council which would consist entirely of dental hygienists elected, and consumers.

Mr Beer: That was my understanding, and I hope that would meet some of the concerns you have had in terms of

the future of the profession and how they develop, because it seems to me at least what this does is to ensure dental hygienists are really more in control, if you like, of their profession and their future. I may have misunderstood, but I thought from your—

Mrs Slivinski: That was the point I was trying to make, that they would be a self-regulatory body consisting of themselves and the public—the consumer or the public. That would sort of help the consumers have something to relate to or grab on to.

Ms Haeck: This is the first time I have heard someone from the public make comments about dental hygienists so I really appreciate your remarks. I would like to put to you that in the hearings we have had so far, the Ontario Dental Association has been very forceful in its comments. It feels dentists should be supervising the work of hygienists, that the hygienists' training does not go far enough to be able to notice possibly serious problems occurring in someone's mouth and thereby avoiding some serious diseases, including cancer, as one member of the faculty of dentistry at the University of Toronto pointed out. What are your comments to that?

Mrs Slivinski: I would be prepared as a consumer to go on to say that, yes, the dental hygienists need to have a little more education as to that type of thing. If you continue on that thinking and leave it the way it is, as I said in my presentation, what happens to me or anyone if we are unfortunately put into a long-term facility? Are you going to forget about us? Someone who spends all his life really looking after his teeth—and it does make you feel good about yourself. It is like the gateway to the body. But you have to train maybe the hygienists a little more in that so that they can pick that up, because if you are always going to say that a dentist has to be present, then you are locking all these doors. You are totally forgetting about the vulnerable. I do not have any problem with their being able to learn that, or anything that they need to learn, to go that one step further. I do not have a problem with that at all.

Ms Haeck: I appreciate your comments and I will definitely keep that in mind.

The Chair: Thank you very much for your presentation to the committee.

MIDWIFERY TASK FORCE OF ONTARIO

The Chair: I would like to call next the Midwifery Task Force of Ontario, Thunder Bay chapter. Please come forward.

All members of committee will have received your written brief. We would ask that you begin by introducing yourselves. You have 20 minutes for your presentation, and we would ask that you leave some time, if you wish, at the end for members to ask questions, if they have any.

Please begin your presentation now.

Ms Pudas: I would just like to preface our presentation by letting you know that this is not the presentation by the Thunder Bay chapter. It was originally scheduled that the Thunder Bay chapter take this spot; however, the provincial organization found itself in the unusual spot of not having an appointment in Toronto, and as it happens that I

am a director of the Thunder Bay chapter as well as the president-elect of the provincial group, this presentation is on behalf of our provincial organization.

The Chair: Just for the record, would you give us the complete name of the organization?

Ms Pudas: It is the Midwifery Task Force of Ontario.

The Chair: Thank you very much, and introduce yourselves, please.

Ms Pudas: My name is Dianne Pudas.

Ms Reid: And my name is Darlene Reid.

The Chair: Welcome. Please begin your presentation.

Ms Pudas: Darlene is the director of the Thunder Bay chapter, so Darlene is here to participate in the discussion part.

The Midwifery Task Force of Ontario was formed in 1983. We are a not-for-profit consumer organization, so I know a lot of people confuse us with the professional group, but we are in fact a consumer-based organization. We have been working towards the legal recognition of midwifery in Ontario. We have maintained a province-wide membership of over 1,000 since 1985, and we now are proud to have 17 chapter groups across the province, as well as numerous contact people.

We have spent a fair amount of our work lobbying different government organizations and, as the legislation is coming closer to a reality, we are switching our emphasis to public education. Just to outline what we have done in the past, we made presentations to the Ontario Health Disciplines Act review committee between 1983 and 1985, and we did that together with the Ontario Association of Midwives and the Ontario Nurse Midwives Association. Then in 1986 we had nine of our chapter groups make presentation to the Task Force on the Implementation of Midwifery in Ontario. In 1989, our regional representatives made presentation to the Interim Regulatory Council on Midwifery, and then in February of this year we made submission to the Midwifery Integration Planning Project, and of course we are proud now to be able to speak to the standing committee on social development regarding Bill 43 and Bill 56 in particular.

Just to comment regarding the health care system as it was structured under the Health Disciplines Act, it is our view that under that act there were some health professions, particularly those professions that traditionally have been female-dominated, that have not always had their skills and expertise acknowledged or used to the fullest, and we see the Regulated Health Professions Act as a start to rectifying this situation. Bill 43 affords us more choices in health professions than did the Health Disciplines Act and, in so doing, it respects our right to choose our health care providers.

We certainly hope that as this flexibility is introduced into our health care system, the focus which now seems to be on crisis intervention will switch over to health promotion, particularly where childbirth is concerned. We expect there will be more community-based health care available and we think this will result in greater consumer satisfaction, as well as more efficient use of our tax dollars.

1420

One thing we are really very particularly pleased with is the increase in the public participation that is planned for all colleges, because we think this will allow for more powerful and more effective public representation. We do have some questions and some recommendations, though, as to how those public representatives will be chosen. We just wonder what the government's view is, what your committee's view is, as far as the qualifications required by a consumer are concerned in order that he or she fairly represents the public.

We are particularly concerned, of course, about the public representatives who are chosen to sit on the council of the college of midwives. We have found in our experience that people who are familiar with issues are able to make more comprehensive, fairer, more informed decisions. We have also found that it is not easy to get up to speed all the time. It takes a fair amount of experience and dedication to learn and being willing to listen to all sides of an issue. One thing we found over and over again in our membership concerns choice of birth place. You can read about the safety of choice of birth place or choice of birth outside of a hospital setting, but until you actually discuss it with people and take time to consider it, it does not come easy for people to support it.

We have three recommendations: first, that those people who are chosen to sit on the council of the college of midwives should have a history of active involvement in the issue of midwifery, and further, that they have a knowledge of the current midwifery system in Ontario and how it grew out of the consumer demand; second, that the selection process for public members be made public so that we have an idea of how you are going to go about choosing them; and finally, that once you do have a short list of people you are considering, that you put on a workshop to outline the parameters of the position so that they will be more knowledgeable about what kind of work is expected. We would humbly like to suggest that the Midwifery Task Force of Ontario would be a good resource for qualified public members.

Basically, we are very pleased about this increase in public representation and we think, together with the increase in number of health care providers, that choice, the public has excellent protection from harm.

Turning our attention to Bill 56, the Midwifery Act, for many years women have wanted changes in the maternity care system, but really it has escalated in the late 1970s and throughout the 1980s. Women have started asking for very specific things. We have found the three things they have wanted are more continuity of care, informed choice and choice of birthplace.

We found that the only health care professional, health care provider who was able and willing to give us those three things was the independently practising Ontario midwife. These midwives provided us with a tool we had never used before, called the informed choice agreement. We have found that this informed choice agreement has helped us to make choices, that we have a lot of information to base our choices on and that the informed choice agreement

recognizes us and our families as decision-makers. It is very clearly laid out.

Despite enormous political and financial obstacles, practising midwives of the Association of Ontario Midwives have offered us these services for several years. During the course of that time, I would just like to say again, "continuity of care, informed choice, choice of birthplace" is the philosophy of midwifery care that has grown. It is a safe, comprehensive care. It has grown out of two things: consumer demand and midwife responsiveness. Those two things together, we feel, have brought about a very special kind of midwifery care here in Ontario.

Looking at the scope of practice of midwifery as outlined in Bill 56, we were very gratified to see that midwives are recognized as the specialists in normal birth, because that is exactly what we have found them to be. But just to go a step further, the Midwifery Task Force of Ontario has as part of its continuity-of-care statement the belief that midwifery care should be an option for all women. This might mean a woman who might now be classified as high-risk. We believe that woman should have the option of midwifery care. Certainly in very high-risk cases you would need to have a physician as your primary care giver, but a midwife could be acting in a supportive role in those situations if it were the choice of the woman.

When we look at the act, we do not see anything in there that would stop that kind of activity, but we would appreciate any information your committee could provide to us regarding this. If this act actually means that supportive care would not be available, then we would like to know about that.

We were also very interested in the proposed amendments made by the Minister of Health recently to your committee, as well as those made by the Association of Ontario Midwives. We would like to comment on those amendments. However, I have to let you know that our organization has over 1,000 people province-wide. We have a rather rigorous protocol that we follow to get feedback from the membership to our board of directors, and because they are recent, we have not had time to complete that process. We are going to have a board of directors' meeting in Toronto on August 26. We will discuss it then and we will let you know, but today we certainly can comment as an executive. I will give you the opinion of the executive committee of the board of directors of the Midwifery Task Force of Ontario.

The executive feels that in order that a woman be provided with continuity of care by her midwife, she needs to have access through her midwife to the same services currently being provided to her via her family physician with regard to normal pregnancy and birth. If this means midwives have to draw blood or do heel pricks to do screenings, if it means she has to insert a urinary catheter or an intravenous or give certain drugs, whether it be prescribing, administering or dispensing, if midwives do not have access to those activities and it interrupts the continuity of care, then we would request that those be included in the scope of practice. We therefore support the Minister of Health and the Association of Ontario Midwives in their proposed amendments to Bill 56, the Midwifery Act.

There is another point that the Association of Ontario Midwives made regarding Bill 43, section 81—I think it is section 81; I may have an old Bill 43; I have the first reading—but it concerns the quality assurance programs and the fact that clients should be protected. Their confidentiality should be protected in the quality assurance programs.

Just finally to finish off, I would like to quote from this wonderful document, *Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions*. The executive committee of this group of people said that "professional regulation is aimed at advancing the public interest, not the interests of the professions." They felt that one way of doing this was by "developing mechanisms to encourage the provision of high-quality care."

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We believe that the introduction of a system of midwifery, which supports the principles of continuity of care, informed choice and choice of birth place will provide child-bearing women with this kind of high-quality midwifery care. We have outlined these three principles in appendix 2, if you would like to read more about our rationale and why it is so important to us. We strongly believe that any amendment that your committee considers regarding either Bill 43 or Bill 56 should give serious consideration as to how the amendments might affect these three principles.

Over the past decade, our members together with their midwives have been instrumental in the development of a very special and, we think, extremely valuable kind of midwifery care. Unfortunately, due to many different reasons—financial, cultural or geographic—not all women have been able to access this care that the midwives from the Association of Ontario Midwives have been able to provide. We believe that these two bills will go a long way to solve that problem, and so we await the proclamation of these bills with both great excitement and with great pride, because we feel we have some ownership of it.

We realize that your committee has been given the enormous and important task of hearing many briefs and considering many views, but we would encourage you to deal with the issues as quickly as possible because there are many women in Ontario today waiting for access to midwifery care.

Mr Wessenger: I would like to thank you very much for your very comprehensive presentation, and I am just going to ask counsel to clarify some matters that you questioned.

Ms Bohnen: Just a comment on your concern that nothing in the bill prevents midwives from providing supportive care. There is nothing in the bill that should prevent that. I think you are aware of the fact that the controlled act that authorizes midwives to manage labour and conduct deliveries does refer to spontaneous, normal vaginal deliveries. I do not know if the kind of supportive care you were referring to meant attending high-risk deliveries or not. I think you were intending to convey the kind of supportive care that a midwife provides during pregnancy and labour with a physician there as the primary-care giver. But in addition to that, any controlled act can be

delegated, subject to standards of practice put in place by the relevant professions, so that delegation also provides a vehicle whereby a controlled act that is only authorized to a physician, let's say, could be delegated to a midwife.

Ms Pudas: Supposing a woman was labouring, everything was normal, and eventually, it ended up in a caesarean birth. The woman is in the operating room, and what we would view as a continuation of supportive care would be that the midwife could be there with the woman, and then provide her with that part of her care that continues to be normal, because there is only a part of her that is high risk and a lot of her that is still perfectly normal that the midwife could care for. It would be horrendous to us to think that a woman would be followed through entirely prenatally by her midwife, then all of a sudden at the end of the labour, goodbye and see you in six weeks or whenever.

Ms Bohnen: I mean nothing in the bill would force the midwife to leave the room. She obviously could not perform the caesarean, but nothing in this bill would require her to abandon her patient, which is what you would be describing as the unacceptable thing.

Ms Pudas: That is right. Yes.

Mr J. Wilson: I, too, want to thank you for a very comprehensive brief. Near the beginning, you mentioned the appointments process and the public members on the college councils. You are aware that the cabinet will be making those appointments. It adds up to a couple of hundred new political appointments for the government of the day, and we have argued for some time now they may have a very difficult time finding qualified people for all those appointments that they have to make at the various college councils.

You make a very good point that you would prefer to see people with some background in midwifery, but I will throw out—to play devil's advocate—it may be helpful and in the public interest and in public safety interest to have people with an open mind who, perhaps, do not know much about midwifery, to sit on the college council. Do you want to comment further on that?

Ms Pudas: I have thought about that, and I can see you would want to have some people to whom this is a new fresh issue. I do not know if there are to be five or how many public representatives on the council of the college of midwives, but if four of them know very little of midwifery, it is going to take a lot of time to get the work done. It would be better, I think, to have fewer people that are really fresh at the issue, and in our experience, the more we learn, the less biased we get, the more open-minded we get.

Mr Owens: Just a quick question around access to hospitals. Do you find at this point difficulty in getting access to hospitals, especially in some of the smaller centres in the north? We were talking about the process where the caesarean takes place, and you would like to be part of that process in a supportive way. Are you having difficulty now?

Ms Pudas: Are you wondering if consumers—we are a consumer organization—if we are having difficulty having our midwives with us?

Mr Owens: That is right.

Ms Pudas: It is very, very specific to the hospital, the particular people who work there, their acceptance. It is specific, too, to the midwives that are working in that community. So it can be very easy or it can be very difficult depending on who is around.

Mrs McLeod: I understand that the Ontario Nurses' Association is one organization that has expressed some concern about the lack of limitations on the section of the act that would propose that midwives be able to administer or inject a substance—that you could administer a substance by injection or inhalation. I wonder if you could tell us what that would mean in practice.

Ms Pudas: You are referring—I am sorry.

Mrs McLeod: I understand that is one organization which may have expressed some concern that there are no limitations. It seems to be a very broad description under the controlled act, the ability to administer a substance by injection or inhalation, so I am wondering what that actually means in practice.

Ms Pudas: As far as consumers go, we recognize that midwives use very, very few drugs. We do not want midwives to have access to any number of drugs. We have a very limited number of drugs that normally labouring or normal pregnant women need access to, so I do not really understand the nurses' concern. It would not be a lot of different kinds of drugs. Is that the concern that they have?

Mrs McLeod: I cannot speak for them. I am really asking what that section of the act means to the practice of midwifery, to have the ability—

Ms Pudas: It means that midwives, if they can administer drugs that we need in normal circumstances, have continuity of care. If they are not able to administer those drugs, we have an interruption of that continuity.

The Chair: Thank you very much for your presentation. During the course of these hearings, if there is additional information that you think would be helpful, please feel free to submit it in writing at any time through the clerk of the committee.

THUNDER BAY DENTAL ASSOCIATION

The Chair: I would like to call next the Thunder Bay Dental Association. All members of the committee have received your written brief. You have 20 minutes for your presentation. We would ask that you begin by introducing yourself to the committee, and please leave a few moments for questions, if you would, at the end of your presentation.

Mr Peltoniemi: My name is Reijo Peltoniemi. I am the vice-president of the Thunder Bay Dental Association, and the members wish to thank the committee for the opportunity to present our views and concerns with respect to Bill 43, the Regulated Health Professions Act, and Bills 47, 48, 49 and 50 related to it.

As time is limited, we would like to address only four areas where this new legislation, as proposed, is not in the best interest of the consumers of Ontario, the government or the professions. I would be happy to discuss other areas

of concern with respect to this legislation with MPPs at a later date.

Our first area of concern is what appears to be the broad ministerial powers granted to the Minister of Health under this new legislation. While present legislation gives the minister extensive power, is this new wording not too broad?

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The new wording under Bill 43, clause 5(1)(d), gives the minister power to "require a council to do anything that, in the opinion of the minister, is necessary or advisable to carry out the intent of this act, the health professions acts or the Drug and Pharmacies Regulation Act." Would this broad power not undermine the principle of professional self-government if the minister is responsible for everything? Perhaps this wording should be reviewed further.

Our second issue concerns Bill 49, the Dentistry Act. The government has always maintained that no profession would be denied any controlled activity they are currently performing. Electrosurgery and laser surgery are examples of forms of energy currently being used in dentistry for surgical procedures involving both hard and soft tissues. Both these forms of energy, among others, are vital to providing the consumer with quality, up-to-date dental care. The legislation, as currently proposed under the Dentistry Act, Bill 43, omits the use of forms of energy as a controlled act. This omission must be an oversight.

We feel Bill 49, section 4, authorized acts should include, "Applying or ordering the application of a form of energy prescribed by the regulations under this act," from Bill 43, paragraph 26(7). Omission of this clause would deprive consumers of quality dental care available today and would prevent the development and use of future technologies, further depriving Ontario residents of the best in available care in the future.

Our third area of concern is under Bill 50, section 4, the Denturism Act. As currently proposed, this act will authorize denturists to provide partial dentures even though they are not trained to diagnose or provide a treatment which will impact directly on the patient's natural teeth.

We believe that properly trained denturists provide a good service to the public, within their present scope of practice, that is, the fabrication of complete dentures to consumers missing all of their teeth.

However, the skills required to diagnose, prescribe and prepare a partial denture are controlled acts, Bill 43, subsection 26(2). These include the taking of diagnostic X-rays to evaluate bone and root support of teeth, prescribing any treatment required to these teeth and supporting structures, and carrying out treatment and alteration of these tissues in order to prepare the patient's teeth and supporting structures to receive a partial denture.

Furthermore, a partial denture is only one option for patients missing some of their natural teeth. A patient should have the right to have all of the available options explained by a knowledgeable and qualified practitioner.

Serious pathology, such as gum disease or short roots under the bone, cannot be detected by a denturist because denturists are not trained to diagnose disease and are not qualified to take or interpret X-rays. Fabrication of a partial denture in the presence of existing pathology will result in

the eventual failure of that partial denture and probable damage to adjacent teeth and supporting tissues. We are concerned about the financial and health costs to the patient, should this arise. Thus, sections 3 and 4 of Bill 50 must be amended to ensure that denturists fit and dispense partial dentures only on the order or prescription of a dentist in order to minimize the potential for harm to patients.

Our fourth area of concern is under the Dental Hygiene Act, Bill 47. Section 3, the scope of the practice states, "The practice of dental hygiene is the assessment of teeth and adjacent tissues and treatment by preventive and therapeutic means and, on the order of a member of the Royal College of Dental Surgeons of Ontario, the provision of restorative and orthodontic procedures."

We believe the wording of this scope of practice is improper. This wording would allow hygienists to treat teeth and adjacent tissues by therapeutic means without the order of a member of the Royal College of Dental Surgeons of Ontario.

To treat by therapeutic means, an individual must be able to prescribe and interpret radiographs, determine pathology, diagnose and formulate a treatment plan and prescribe the various treatment modalities, including antibiotic and other drug therapies, surgical procedures, tissue alterations and scaling and root planing. As dental hygienists are not trained or qualified in interpretation and diagnosis and prescription of these procedures, how can they treat by therapeutic means?

As proposed, this legislation could be interpreted to mean that a hygienist could set up independent practice and, with limited restriction, provide preventive services and some therapeutic services without a previous diagnosis, assessment or order of a dentist. Is this the intent of the legislation? The Thunder Bay Dental Association has had no representation by the members of the Thunder Bay Dental Hygienists' Association indicating that they wish an independent scope of practice.

Proper cleaning and polishing of teeth almost always requires a scaling component above and/or below the gums. This scaling can only be carried out under an order of a dentist as it is an authorized act under Bill 47, section 4. Thus, it is difficult to understand how a patient could visit a hygienist in independent practice and receive a complete cleaning. This could fragment a patient's treatment requiring the patient to travel back and forth between a hygienist and a dentist in order to receive a cleaning. The continuity and complete service a patient receives under a dental team, as it exists today, would be lost.

Also, as our population ages, an ever-larger number of people are receiving joint replacements, heart bypass and valve surgery, and transplants of heart, kidney or other organs. They are becoming more and more commonplace. These patients may require prophylactic antibiotic coverage prior to dental treatment, such as scaling and cleaning or polishing of teeth. This is done to prevent serious and possibly life-threatening infections in those replacement joints, transplants or heart valves.

If a hygienist has independent practice, who will know to write the appropriate prescription for prophylactic antibiotic coverage and who will order the prescription to be written? Failure to diagnose the condition and prescribe

the appropriate antibiotic coverage could result in a possible life-threatening infection for the patient.

While we feel that hygienists are technically very well trained and highly skilled in carrying out their present duties, we feel strongly that all treatment provided by a hygienist should be on the order of a member of the Royal College of Dental Surgeons of Ontario. This would continue to provide the safe, high-quality dental care Ontario residents receive today and would expect tomorrow. Therefore, to ensure that the dental hygienists' scope of practice is consistent with their authorized acts, Bill 47, section 3 should read:

"The practice of dental hygiene is the assessment of teeth and adjacent tissues and, on the order of a member of the Royal College of Dental Surgeons of Ontario, treatment by preventive and therapeutic means and the provision of restorative and orthodontic procedures and services."

This would be less restrictive than present legislation and will not prevent hygienists from providing services previously prescribed by a member of the Royal College of Dental Surgeons of Ontario in community settings such as homes for the aged, chronic care institutions and group homes.

I would like to conclude my remarks by thanking you for giving me this opportunity to voice the concerns of the Thunder Bay Dental Association with respect to this proposed legislation.

Mr Wessenger: I would like to have counsel give some clarification with respect to your comments concerning forms of energy.

Ms Bohnen: The controlled acts set out in paragraph 26(2)(7) of the main act refer to applying or ordering the application of a form of energy prescribed by the regulations. The government's intention is to list in a regulation those forms of energy which, in consultation with the professions, are identified as hazardous. And then in that same regulation, authorize to the appropriate health profession their usage of that form of energy.

A couple of professions—dentistry and optometry come most to mind—have objected, asking why is it that the Medicine Act specifically authorizes to physicians this controlled act but not in the Dentistry Act and not in their act. The reason is that the list has not been prepared; the regulation has not been prepared. That will not happen until there is consultation with the professions. However, it is certain that whatever is on the list, physicians will be ordering and applying those forms of energy because they do have the broadest scope of practice containing almost all—not all, but almost all—of the controlled acts. There is certainly no intention on the part of the government to prevent dentists from using what are identified as hazardous forms of energy in their practice.

Mr Owens: A quick question to counsel: What types of restorative procedures do you envision hygienists being able to perform?

Ms Bohnen: Under their proposed act they do not perform restorative ones, except on the order of a dentist. But I believe that some dental hygienists work with dentists and dental specialists who do restorative work and that they would perform procedures of that nature and assist

with others of them. But those are not the types of procedures that they could do independently.

The Chair: Thank you for your presentation. We appreciate you coming before the committee today.

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LINDA MICKELSON

The Chair: Dennis Batigelli has cancelled, and Linda Mickelson is next. I believe there is a written submission that you have given to the committee?

Ms Mickelson: That is correct.

The Chair: All members have received it. You have 10 minutes for your presentation. I would ask that leave a few minutes at the end for committee members.

Ms Mickelson: Madam Chair, committee members, my name is Linda Mickelson. I have been a dental hygienist for over 27 years. During these years of dental hygiene practice, I have had a variety of experiences. Presently, I work full-time in clinical practice for six dentists in general practice here. For many years, I taught clinical dental hygiene at Confederation College in Thunder Bay.

Eleven years ago, I was one of the first two dental hygienists elected by my peers as an official dental hygiene observer on the council of the Royal College of Dental Surgeons. My term with the RCDS is unique. Currently dental hygienists are governed by the Royal College of Dental Surgeons. However, we are not members of the RCDS. Therefore, the dental hygiene official observers sit on the college council and other RCDS statutory committees as official dental hygiene observers without voting privileges. I can tell you, you do not get lobbied much if you do not have a vote.

Today I am not representing any group. The comments in this presentation reflect my personal experiences and are based on the knowledge I have acquired during my tenure. I believe in the value of a clean, healthy, oral environment, and also in the capabilities and integrity of dental hygienists.

The mouth is the gateway to the body. The oral environment reflects health or disease of the whole body. The mouth is important for verbal and non-verbal communication. A healthy mouth is just as important, if not more so, than healthy feet—and the public has access to unsupervised chiropodists who provide foot care. The condition of our mouth determines what we are able to eat, and therefore, how we fuel our body.

The primary function of the dental hygienist is to teach the hows and the whys of a healthy oral environment. By skilled technical means and instrumentation, we remove calcified plaque mechanically. We start the healing process. Verbally we attempt to empower the public to achieve and maintain a healthy, functional, oral environment.

I am really excited about this new legislation. Now dental hygienists will be responsible and accountable for the dental hygiene services that they provide. They will have their own code of ethics, which will be a guide for decisions involving colleagues, employers and co-workers. The patient-client will have to be the first consideration.

This new legislation will allow greater access to oral health services by the public. Under the present dental

regulations, the supervision interpretation is very restrictive. A dentist must be on site and examine each patient. This is neither practical nor cost-effective in community living centres, community health centres, hospitals or other institutions.

There are a few specific points that I will bring to your attention with regard to Bill 47, An Act respecting the regulation of the Profession of Dental Hygiene, and Bill 43, the Regulated Health Professions Act. These specific points are: scope of practice, controlled acts, delegation, the register, powers of investigation, and transitional councils.

Scope of practice: It is my understanding that the professions control their own members under the scope of practice statement. Presently the dental hygiene scope of practice statement is not in accordance with the same principles used for the other professions, as it refers not only to the practice of dental hygiene but also to "on the order of a member of the Royal College of Dental Surgeons." Because "on the order of" is included in the authorized act statement, it does not need to be in the scope statement. I recommend that "on the order of a member of the Royal College of Dental Surgeons" be removed from Bill 47, section 3, in order to be consistent with the other acts.

Controlled acts: Dental hygienists do procedures such as pit and fissure sealants and topical fluorides on teeth. I recommend that the word "on" be added so that it reads "in, on or below," or that the wording be changed to read "procedures that alter the surfaces of the teeth."

Delegation: I am concerned about delegation. Consumers of dental services assume certain things. They assume that the instruments are sterile, and that the room and the equipment are clean. It is important that all dental personnel are knowledgeable about disease transmission, sterilization and cleanliness. Some assistants are not formally trained.

I believe it is important that the dental regulations state that unregulated persons employed to assist in dental offices be properly trained and educated. I recommend that delegation be made only to assistants who are formally trained in the educational system. Also, since the dental hygienists' authorized acts are controlled acts for dentists, I would expect that dentists would not be permitted to delegate dental hygiene controlled acts to unregulated persons.

The register: Generally dental hygienists are women, usually employed in dental offices. Is their operator their business premise? Presently their home addresses are listed in the RCDS register. Many women, to protect themselves, would not want their home address to be public. I recommend that it be specified that the register contain a designated business address.

Powers of investigation: This states that the investigator may examine but it does not specify whether the investigator can obtain a copy of the records. Also, will there be a provision to provide access to other persons who are employers of the dental hygiene members? There needs to be assurance of access to records so that the employing persons will release records pertinent to the investigation.

Transitional council: Bill 47 states that there will be a transitional council after third reading. From this dental hygienist's viewpoint, it cannot be too soon. Working without our present regulatory body makes progress difficult. There is no official spokesperson for dental hygiene.

Presently self-regulation of the professions is mainly reactive and punitive through complaints and discipline. I believe that with the inception of continuing competence and quality assurance the colleges will become proactive, rehabilitative, and preventive in their manner of self-governance.

Finally, I think all the political parties are to be congratulated, as well as the government staff, and certainly the review team. This has been a monumental task. However, I think it is an example of how political parties can work together for the betterment of the public.

Mr Beer: Thank you for your submission. One of the concerns that has been expressed by a number of representatives of dentists groups or individuals, and was expressed again here today, is that of dental hygienists being involved in the mouth and how you are going to be allowed to do that in an unsupervised way. When you are practising—I note that you are working with six dentists currently—what has that meant in a practical sense? In effect, is there an understanding which evolves? If you are doing a number of things on your own—and you say you do not want them all to be “on the order of”—what is the actual practice, as opposed to the law as it stands? How tightly supervised are you by the dentist you would be working with? What is the nature of that control?

Ms Mickelson: I suppose—and I have been around for a long time—that it is a question of the nature of the ward supervision. I have been around long enough that I have seen the interpretation of supervision go through many stages. When I started in practice as a dental hygienist back in 1964 here in Thunder Bay, I think the process was what you would call “on the order of.” Then various things occurred over the years and the interpretation of supervision has been tightened up. If you look at supervision in any other areas of society, I think in dental hygiene the interpretation of supervision is probably more restrictive than any other way.

If I may give you my personal interpretation of how supervision should work or how “on the order of” will work in the future, I see it as a collaborative process. Supervision in other areas, whether it is the penal situation or social work or that sort of thing, works so that there is an exchange both ways and so that there is a discussion taking place with regard to the client. Very often that is not the case presently. I think supervision sometimes now can be interchanged with the word “control.” I do not know whether that answers your question.

The Chair: Thank you very much for your presentation. On behalf of all the members of the committee as well as government staff and task force members, we would like to thank you for your very nice comments.

SALME LAVIGNE

The Chair: Salme Lavigne; we have all received your submission. I ask that you introduce yourself for the record of Hansard. You have 10 minutes for your presentation, and if you would leave a few minutes at the end in case there are any questions we would appreciate that. Please begin now.

Ms Lavigne: My name is Salme Lavigne. I have been a dental hygienist for the past 24 years and a dental hygiene educator since 1977. I have been directly involved with designing curriculum for dental hygiene programs both provincially and locally.

Through my personal experience as an educator, I view dental hygiene as a dynamic profession whose members are capable of providing quality care to their patients. In addition, they possess the knowledge and skills necessary to initiate and manage community dental health programs in any type of setting, whether it is a nursing home, a chronic care facility or a children's fluoridation program. Thus, I am pleased to see the elimination of “direct supervision” and the addition of “on the order of” in the new legislation, as I believe the dental hygienist is well prepared to assume this responsibility.

Presently dental hygienists must attend college for a period of two years for skill preparation and development. They are educated in all aspects of dental hygiene procedures, including not only the technical aspects but with the major focus on the development of assessment skills. This includes the understanding of any medical implications disclosed through the taking of a thorough medical history, including drug interactions. The safe treatment of patients is paramount in this assessment process. This enables the hygienist to assess the overall health of the patient in order to make appropriate recommendations for patient treatment and continued self-maintenance.

Under the diagnosis section of Bill 43:

“A ‘controlled act’ is any one of the following done with respect to an individual:

“1. Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion.”

Since dental hygienists are taught to assess the condition of the oral soft tissues, they are capable of communicating to the individual the condition, dysfunction or disease. In addition to assessing the nature of the condition of the patient's soft tissues, they are well qualified in judging the time necessary to treat each individual patient. The dental hygienist is actually better able to judge the time necessary to treat soft tissue conditions than the dentist who is directly supervising under the present regulation. Therefore, I believe the dental hygienist is well prepared to accept the responsibility of making these judgements.

Again under the same section, paragraph 2, involving procedures:

“2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.”

I believe certain procedures performed by dental hygienists on tooth surfaces which alter the surfaces of the teeth, such as application of fluorides and pit and fissure sealants, should be included as controlled acts. Presently they are in the public domain. I therefore recommend that the

wording be changed to include those procedures which alter tooth surfaces.

Under the delegation section of bill 43, which is section 27:

"(1) The delegation of a controlled act by a member must be in accordance with the regulations under the health profession act governing the member's profession."

When the dentist delegates a procedure, I would like assurance that the procedure be performed by someone formally trained. For example, individuals responsible for sterilization of dental instruments must have knowledge of infection control in order to prevent the transmission of diseases such as AIDS and hepatitis. Therefore, I recommend the regulations address all non-regulated procedures.

Under the quality assurance section of Bill 43, which is section 78:

"The council shall make regulations under paragraph 22 of subsection 91(1) prescribing a quality assurance program."

I am happy to see the inclusion of quality assurance in the legislation. Presently there is no provision in the legislation that professionals maintain competency. Currently, in a private practice situation, dental hygienists often may not have control over the quality of services provided. Sometimes time restraints directed by the supervising dentist restrict the quality of the delivery of care. With the inclusion of a quality assurance program for all professions, both dentists and hygienists will be obligated to maintain standards of practice through continuing education programs.

In conclusion, it is an exciting time for the dental hygiene profession. In response to this legislation, the new educational opportunities that will be created will result in better health care delivery to the public.

Mr J. Wilson: In the Thunder Bay area, one of the other witnesses prior to you mentioned that there was a void there and the need for dental hygienists to go into nursing homes and chronic care homes. Can you explain briefly what the situation is here? Is there really a void, that dentists are not covering those homes up in this area?

Ms Lavigne: Basically, right now there are not any dental facilities as far as I know in any of the nursing homes. I believe there is a group of dentists who have formed a volunteer committee and they do go around and help individuals out in nursing home situations, but I do not think they are delivering any treatment. There are not any hygienists or dentists hired by institutions other than the Ontario hospital, I believe, the psychiatric hospital.

1510

HANUSIA TKACZYK

The Chair: Hanusia Tkaczyk.

Ms Tkaczyk: My name is Hanusia Tkaczyk. I have a master's degree in psychology and I have been practising in this area for over 10 years. The concerns I have are concerns of many other clinicians like myself, and these are in two major areas of the Psychology Act as proposed: first, the inclusion issue or access to registration, and second, the diagnosis clause. Regarding the first, the legislation as currently proposed will use the Ontario Board of Examiners in Psychology as the transitional body to the college of

psychology. Unless that is amended, this will result in a grave misrepresentation of psychology in Ontario today.

The current reality is that fully two thirds of practitioners in psychology are not PhDs. Most of us have MAs, which involves five or six years of university training. We work independently of the psychologists. We do exactly the same type and quality of clinical work and carry exactly the same size of case load. We are not assistants or technicians. Our clinical job assignments are completely interchangeable with those of the PhDs and, as a matter of fact, in northwestern Ontario particularly, until a few years ago when there started to be more psychologists in the area, we were doing all the work and doing it quite competently.

But in Ontario we are nothing. We are second-class citizens in our own agencies and we cannot attain the full status of recognized and responsible professionals within our own provincial organization. This is because the entry requirements, as they stand and as they are defined by the PhDs who are in control there, are academic credits from a PhD program. This is a body of background knowledge about human behaviour, but these programs do not necessarily include training and how to work with clients, particularly programs that specialize in research or experimental work or include it to varying degrees.

Meanwhile, clinicians who have had years of hands-on experience, who have often taken extensive clinical training from established experts in the clinical field, are shut out. There is absolutely no way, no opportunity, for us to be registered and accountable. OBEP and the psychologists will say to you that is not necessary because they cover us through a system of supervision. Well, quite frankly, it does not work. The numbers are unworkable. For example, just in the region of northwestern Ontario there are 30, 40 or more non-psychologists who rarely if ever see a psychologist for supervision because these people cluster in Thunder Bay and in Kenora. They do not get out to the other areas.

Psychologists and other clinicians are so busy that there is hardly time to do supervision anyway. There are so many people to be seen. If the psychologists were to supervise us according to the OBEP guidelines even as they exist, there would be so little time to see any of their clients that it would just be unworkable. The reality is that there is an absolute minimum of supervision. There is occasional contact, some discussion as if between colleagues as to what is going on, but really very little.

Yet, you should be aware that most PhDs are quite comfortable with this minimum of supervision, although supposedly their licences are on the line, so you would think they would be prepared to argue that we are competent professionals and do not have to have somebody looking over our shoulders at all times. Yet the psychologists have given themselves sufficient power that they could prevent us, their supervisees, from working in an area of their established competence if the psychologist does not have training there. So, for example, if I had years of experience and background work in neuropsych and I get a new supervisor who does not have that, he or she is supposed to say to me, according to the OBEP guidelines, "You can't do that any more unless we find somebody who

is trained in it who has a PhD also and can supervise you." In northwestern Ontario where resources are scarce that is a real problem.

The current supervision system allows a brand-new grad from the PhD program to tell a veteran who may have 20, 25 years of experience what to do. If anything, it would probably be more useful for the new grad to benefit from the experience of someone who has been there, who has learned skills which cannot be taught and are simply not taught in academic circles. As a matter of fact, there is nothing in PhD programs preparing these people to supervise anyway. There are no courses in it.

Experienced non-doctoral clinicians in psychology do not even have a proper title; we exist by a variety of strange names. We are trained in psychology, have experience in psychology and practise psychology, yet we are not recognized and OBEP has been actively lobbying to continue the current practice of threatening us with legal sanctions if we attempt to communicate by a title, designation or description anything that reflects our valid and hard-earned abilities.

If the purpose of the current legislation is to assure the public of a high quality of health care through duly regulated and legally accountable professions, then the non-doctoral clinicians in psychology must be included, but using OBEP as the transitional body will simply perpetuate an old system that is closed to anyone without a PhD. Inclusion of non-PhDs would result in legislative protection for the public of Ontario by realistically reflecting current psychological practice. This would be based on meaningful entrance criteria that reflect not only the very necessary academic credits, but equally valuable real-life experience in the profession and other forms of valid clinical training.

Regarding the second issue, the diagnosis clause, as proposed now this could only be done by members of the college, and if OBEP remains in charge, that will effectively limit it to the psychologists. There are many clinicians who have training and experience in areas other than psychology per se who can and do communicate conclusions about psychologically based disorders; for example, social workers, addiction counsellors and others. Why prevent them from doing their work?

The basis of treatment for most clinicians is some conclusion reached after an assessment period, and the professional is normally expected to communicate that to the referring agency.

Again, let's take an example, particularly in northwestern Ontario in areas where there is not a psychologist anywhere on site. Let's say the clinician gets a referral from a family doctor about a client. Is this person depressed? Do they need therapy? What does the clinician do under the new legislation? Do they wait until a PhD turns up to sanction their conclusion and communicate it? Do they consult on each and every case? That is unworkable because of the numbers involved, and you heard a bit about that earlier today. Do they ship the client to Thunder Bay, several hours away? None of these scenarios reflect a decent quality of health care for citizens in northwestern Ontario, who already do without quite a lot. Clinicians I have spoken to in preparing for this presentation are saying,

"I'm not going to be able to do my job any more if this is upheld as it stands."

Of course, diagnosis is a very serious business and should only be done by people who are duly qualified and the public deserves protection of this particular clinical activity. However, limiting it to PhDs, limiting it to those academic requirements, is not the answer.

Again, within psychology, experienced clinicians are hampered or discounted. Imagine doing all of the testing, all of the assessment, interpretation, treatment planning and report writing for a client. Then you have to have a psychologist co-sign it. This is somebody who may never have clapped eyes on your client, would not know him if he fell over him in the parking lot. Yet the psychologist has the legal responsibility to co-sign because only he or she has the legal right to diagnose.

That system exists now. The co-signing implies that the non-PhD was some kind of technician, and that is not the case. Rest assured that few agencies have the luxury of having us doing just testing. We are all carrying a full case load. There is lots of work to be done. We are as capable and as ready to be responsible for our actions as the PhD colleagues.

More important, I think this co-signing system is dishonest. It implies an ownership of the work and a responsibility for it which deceives the public. We non-doctoral clinicians are concerned about it and we want to see that end.

In diagnosis and in all areas of treatment, non-doctoral clinicians in psychology no longer wish to ride on the coattails of their PhD colleagues. If this legislation is to carry out its stated purpose, we must be included. We are the bulk of service providers in psychology. We are prepared to be directly accountable for what we do, and we find the current supervision system incapable of doing that.

The public deserves an accurate and accountable system of professional regulation. The best way to assure this is to require that the College of Psychologists have not only PhDs but also non-PhDs who have full status and equitable representation on all relevant boards and committees of that college. I urge this committee to amend the legislation or make whatever recommendations are necessary to see that this is carried out. That concludes my presentation.

Mr J. Wilson: Thank you for the presentation. I and my colleagues in the Ontario PC caucus have a great deal of sympathy for the non-doctoral clinicians. We have all been visited by a number of those, and also the PhDs. At one point you do begin to think it is kind of a turf war.

But having said that, I would like to take this time to just ask the parliamentary assistant and staff, through him, what the thinking of the review committee was in this area. You made a comment earlier today that it is something the committee is going to have to work out, but what did the review people have to say about the non-doctoral?

Mr Wessinger: I will have staff reiterate and perhaps further elaborate on that point.

1520

Ms Bohnen: The review really did not consider entry requirements to become a registered member of a profession. It was concerned with identifying the professions to be regulated, establishing the structure for regulation, what

their scopes of practice should be and so on, but it did not address for any profession what the qualifications should be, because those are the responsibility of the governing body when it makes its regulations. Those regulations will not come before a committee like this, but under this legislation they may well, and in all likelihood will, go before the Health Professions Regulatory Advisory Council.

Mr J. Wilson: But did the question not come up when they were discussing the transitional council, specifically for this bill for psychologists, because the transitional council is made up of the old council, as I understand it.

Ms Bohnen: I think you should ask Alan Schwartz that. My impression is that the answer is no, but I think you should ask him that.

The Chair: Thank you very much for your presentation. I appreciate your coming before the committee today.

TED MURPHY

The Chair: Ted Murphy? You have 10 minutes for your presentation. We have all received a copy of your written brief. Please begin your presentation now and we would ask that you leave a couple of minutes at the end for questions.

Mr Murphy: All right. As a private citizen, I have just come to speak for the chiropractic association, and I will turn over to page 2 on the little résumé that I handed out.

I am told that suggested new legislation would not recognize the ability of chiropractors to diagnose knee joints and other non-spinal joints. The new law would recognize that only medical doctors can do a complete diagnosis of a knee disorder. I think this runs quite contrary to my own experience and it is rather hard to understand. I have been treated for about the last 15 years by a chiropractor, and I have found he seems to have a much better understanding of the knee problems than anyone else. From the point of view of the patient and the public, I think the law should be encouraging freedom of choice, recognizing the work that chiropractors do and do well.

Also, I have difficulty with the idea that they cannot diagnose. I do not know how they are going to treat if they cannot diagnose.

On the front it just gives my background as involved in athletics all my life and with the physical education association of Ontario and as a consultant with the Ministry of Education for 15 years and so on. The injury I picked up at McGill University, and it is something that seems to catch up to you as you get older and older. But I have found Danny Gleeson. He is a local chiropractor who is, I think, one of the tops in his field. David Irwin, as many of you know, of the Crazy Canucks, the skiers, gives Danny credit for keeping him on the ski tour. Also I think your infamous Maple Leafs from Toronto sent down Wendel Clark for two treatments—

Interjection.

Mr Murphy: Yes, I am sorry about that. They will be good next year. They brought him down twice for Danny to work with and they brought Danny down twice to Toronto to work with Wendel Clark.

I feel that in many ways they can be very beneficial. Also, without the ability to diagnose, it is going to really cut down their ability to help people. That is all that I have to say. Are there any questions?

Mr J. Wilson: Just a quick question that is not in your presentation: You are obviously fond of chiropractors, but I am wondering what you think about us now moving to legislate, give them authority to use the term "doctor." A number of them use it. They are not supposed to use it.

Mr Murphy: I just accept it more or less, because a lot of them use the term "doctor."

Mr J. Wilson: Our concern is that the public may think these people are all MDs.

Mr Murphy: Most of the people associate where they go. They look at the people as chiropractors and a doctor of chiropractic, not as a doctor as far as medicine is concerned.

The Chair: Further questions? Thank you very much for your presentation. We appreciate your coming today.

Gary Sartain? We have tried to contact the Canadian Association of Pastoral Education. Apparently they have been contacted and are on their way. We are a little ahead of schedule, so I would suggest that we recess for about 10 minutes, get ourselves ready to depart, and reconvene so we can hear the last presentation. Hopefully they will be here within 10 minutes. Gary Sartain? He has not arrived yet. All right.

As this is the first time that this committee has travelled together out of town, the clerk has asked me to remind everyone to ensure that the airline stub is submitted to the clerk at the end of each travel day. That is what is left of your ticket. Do not throw it away. They take out two pieces of your airline ticket and the remaining stub has to go to the clerk—not the boarding pass. So if we could just make sure that every member is aware of that, we will do that. We will just recess for 10 minutes.

The committee recessed at 1526.

1555

CANADIAN ASSOCIATION OF PASTORAL EDUCATION

The Chair: I call Gary Sartain. Welcome. I ask that you begin your presentation. You have 20 minutes. We ask also that you leave a few minutes for members to ask questions, if they have any, at the end of your presentation.

Mr Sartain: My thanks for being allowed to appear before you. My name is Gary Sartain. I am an ordained clergyperson with the Evangelical Lutheran Church in Canada and a fellow with the College of Chaplains. Until last Friday I was chaplain and manager of pastoral service for McKellar General Hospital here in Thunder Bay. Today I begin a new position as northwestern Ontario regional coordinator of chaplaincy services for the combined ministries of Health, Correctional Services and Community and Social Services for the province of Ontario.

I am in the process of becoming a provisional teaching supervisor for the Canadian Association of Pastoral Education, which is the program through which most spiritual care givers in institutional settings are trained in Canada.

It is the Northwestern Ontario Section of the Manitoba-Northwestern Ontario Region of CAPE on behalf of which I speak to you today regarding the proposed legislation. Our particular concern is the diagnosis clause, which we feel puts us, our immediate supervisors and our employing institutions in legal jeopardy for continuing to do our jobs appropriately and in the very way required by the standards of the Canadian Council on Health Facilities Accreditation, the national accreditation body for acute and long-term care institutions.

At the very time that there is a growing recognition of the need for and the push towards holistic, team-based patient care in our health care institutions which includes attention to the spiritual dimension, a potential barrier looms that will inhibit the functioning of spiritual care givers and give those considering making them a part of their team cause for concern.

The proposed legislation would preclude those of us in chaplaincy who are unregulated practitioners from "Communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion." I quote from paragraph 26(2)(1).

While the list of examples is almost endless, let me share with you several recurring scenarios from my previous employment that I would be constrained from doing should this paragraph remain.

First, at McKellar General Hospital, when a person was brought into emergency with vital signs absent, it was my responsibility to contact family and get them to the hospital and/or to sit with them in a private area while the emergency response team worked on their loved one. I would act as the liaison between the team and the family, passing on information that the medical team wished them to have—ie "We have succeeded in getting his or her heart going," "Things are going okay, you can relax a bit now," "We don't hold out much hope but are doing all we can," etc—as dictated by the situation and the needs of the family. I should add that the bottom line of this was that medical information was dispensed only with the permission and with the direction of the physician or medical team. Often, when a person was pronounced dead, the team would ask me, who had the relationship with the family and the expertise in handling such situations, to bear the news. Once the family had gotten through the shock, the attending physician would come in and provide details.

While I was never making the diagnosis, my communicating a diagnosis on behalf of the medical team was integral to our handling of a difficult situation for a family in the most caring way possible.

By contrast, I think back to how, early in the development of the chaplaincy program at McKellar before this team approach was in place, a person had been brought in in the middle of the night dead on arrival. I called the family asking them to come to the hospital, not advising of the medical circumstance at that point, and then sat with them for 45 minutes until the physician who had pronounced the patient dead came and passed them information. He was

unable to do so before that because he had gotten tied up with the delivery of a baby prior to their arrival at the hospital.

That family felt betrayed by me and by the hospital, that we could let them linger that long in limbo making small talk and acting like there was potential for things to be all right when we really knew otherwise. I can even remember them asking me to pray for the person to be okay and I was constrained from telling them the truth. My feeling is that the present paragraph will force the team back into this kind of untenable situation, which is not in the best interests of patients and families nor of the care-giving team.

Second, it was common practice on our intensive care unit for me as chaplain to be present, along with the patient's total care nurse, when a physician held a consultation with a family, particularly when the circumstances were dire; ie, impending brain death, organ donation requests, etc. I would remain for family support when the other members of the team returned to their medical duties.

Often I would discover that families had misheard or misinterpreted what the doctor said. Sometimes the appropriate thing was to get him or her back to restate, if it was convenient or deemed necessary, but when this was impractical or impossible, I would restate what was said, not making the diagnosis but communicating it in a way that facilitated the process of the family coming to grips with the situation. If I were unable to do this, and I believe the present wording of the proposed legislation would preclude it, the family would be left in limbo and their relationship with the physician and nurse jeopardized. The very people the legislation seeks to protect would be harmed.

Third, as a chaplain and member of our palliative care team, I was seen as the resident "specialist" in the area of grief. Often I would receive referrals from within and without the hospital to see and assess a person around a situation of loss.

When the referrals would come, the bottom line for the person referring and/or the referred was, "This is what is happening, is this normal?" "Is this a normal grief reaction?" "Do I need psychiatric help?" I was being asked now to make a diagnosis that the counsellor and person referring both thought was within the scope of my expertise and practice. How does one refer, say, for psychiatric help on the one hand, or deflect from the busy psychiatric team where appropriate on the other, without making and communicating a diagnosis that you would foresee and hope the persons involved would rely on? Yet the proposed diagnosis clause would preclude this. There must be provision to allow chaplains to make and communicate a diagnosis that is within the scope of their expertise and practice. My example is the diagnosis around issues of grief and so forth as contrasted to a medical diagnosis, such as when someone has a cancer or something like that, which would be totally outside of my expertise and practice.

We are well aware that it has been the contention of the Ministry of Health that it is not the intention of the legislation to preclude chaplains doing the above. We do not dispute your intentions, but that could change. Furthermore, we are concerned that the wording of the legislation will take precedence over the intent of the writers in our courts of law. We fear that disgruntled clients will initiate

prosecutions which, even if they are not successful in the sense that we are found guilty of contravening the intent of the legislation, will still be costly in terms of finances and reputation to defend. We implore you, therefore, to revise the clause to reduce our vulnerability. I must clearly state that we have no opposition to the general goals espoused in this legislation, but we do feel strongly that revision of the diagnosis clause is mandatory.

We believe the latest draft proposal of the Coalition of Unregulated Practitioners does the job for those working as a part of a health care team, when it suggests that one cannot perform a controlled act unless the person is authorized by a health professions act to perform such act, or has been delegated the responsibility by someone so authorized. In each of the examples I quoted you, that was happening. The authorization was either given by the team or in the process of the referral. We remain concerned for chaplains in other settings, however, and for pastoral care givers in parishes. We understand there was an amendment to the act to exempt clergy from a particular faith group from treating their own parishioners by prayer or spiritual means in accordance with the tenets of their religion. But often these clergy are sought out for counsel and advice by non-members, particularly in sparsely settled areas such as in the north. Are they still exempt by wording as well as by intent? We would doubt it, and we see it as mandatory that they be protected. Perhaps, in the end, the solution is to have a clause which states that the controlled act concerning diagnosis applies only to the regulated.

Finally, a personal observation. The Ministry of Health response to date seems to indicate a significant lack of understanding of the scope and nature of the profession of chaplaincy and the creative interface between community clergy, health care professionals, and health care institutions, particularly as it plays out in more remote or rural areas where resources are limited. I share that just from the fact that this response about the clergy was the initial response to our concerns.

Because of this, and in hopes of helping you make revisions to the diagnosis clause that I hope I have helped you realize are necessary, I am appending sections from the McKellar Pastoral Care Policy and Procedure Manual, written by myself, that delineate the functions, duties and responsibilities of the various providers of pastoral services, from paid professional to lay volunteer, including community clergy. I am also appending a copy of a letter to you from two chaplains at St Joseph's General Hospital in Thunder Bay who concur with the presentation here. Other area chaplains and clergy have also been mobilized and will be writing you. I thank you for the opportunity to appear before you.

The Chair: Thank you very much for your presentation. Before I call for questions, I would like to tell you and anyone who is here that if at any time during the committee's deliberations there is additional information you would like to make available to the committee, you can do so in writing to the clerk of the committee. That is for any individual, organization or group of individuals who would like to submit. Just for the information of everyone here, we have also had presentations in video form. As long

as there is a covering letter, we would be happy to receive any information anyone would like to submit in any written or audio-visual format. All written material does become part of the public record.

Mr Martin: I want to thank you for coming forward today and bringing what I think is a really interesting perspective on this whole thing from the view of the chaplain. Certainly it highlights a concern we all have re how this Regulated Health Professions Act has a tentacle that reaches out into other areas and has potential to impact. I think that is particularly acute in the north, which is, as you say here, an underresourced area. We are for ever trying to find someone who can respond to a situation, a crisis, and now with maybe the potential to have a suit brought. Perhaps you might want to expand on that a little further.

Mr Sartain: One of the things we have been working very hard at in the north and one of the reasons I was really enthused about taking my new position when the opportunity afforded itself is that we are working very hard at training people to be spiritual care providers. The emphasis has changed significantly. It used to be that a chaplain went into an institution representing his own faith and functioning from the tenets of that faith group, often only with people of his own faith group. Now the emphasis is on determining what the spiritual resources are of the client or patient or family that you are meeting and using those resources and finding ways to mobilize and strengthen those kinds of resources. So a lot of training is going on along that line.

1610

Two years ago we had a training program here funded through chaplaincy services. Last year we did a training program in Fort Frances, Ontario. The people we trained were people doing chaplaincies in various institutions on a part-time basis who had had no training. One of them was in a home for the aged, another a nursing home in Kenora, one in Fort Frances in a jail, another in the hospital in Fort Frances, and another was a community clergy person in Emo who was very involved in that area in the areas of sexual assault and wife abuse and so forth.

We are also concerned about what kinds of implications this has for training, because if the supervisor, whether it is the educator or the institution, is liable for one of these students communicating a diagnosis, what does that mean? Probably we would be protected, but I can see certain administrators who may have a tendency from the outset to not want to take the risks involved, using that as an excuse not to proceed. So we are very concerned that as doors are opening for chaplaincy in areas that have previously been closed people will feel that in order to protect themselves they are going to have to back off.

I was also very involved when the Dryden disaster occurred here, and I would have to honestly ask questions about whether I would feel free to go to the airport and function in the way I did that night with this sort of thing involved. I am sure I probably would still do the same thing, but it is a concern that we have to start thinking about it. It is not that we do not always have to think about what is ethically moral and appropriate in terms of how we

deal with people, and I think we do that, and that is why I included some of the things from the McKellar manual that I think are very important, but we are concerned about going beyond what is necessary and actually inhibiting constructive work being done. I agree: the loose cannons just cannot be allowed to function, but the people who are being an integral part of our medical health care teams and whose work is being really appreciated, I think we need to facilitate that rather than hinder it.

Mrs McLeod: Obviously the concern you bring forward is a very real one, and I think all members of the committee have heard it in other settings and other occasions, but one of the things the committee and ultimately the ministry and the minister will have to struggle with is whether or not there is a cure which is less drastic in its implications than the presenting problem. I wonder, with that in mind, if you could say a little bit more about how theoretical the concern is in a legal kind of way versus how real you think the prospect would be of a chaplain who had been working within a counselling setting actually prosecuting afterwards.

Mr Sartain: I think it would be very real, and the reason I think it would be very real is that in the three years I was at McKellar hospital I wrote two letters for doctors and one letter for a nurse to their respective col-

leges where they were being challenged by people for things that just had no basis. One of the things, for example, was a physician who was accused of not doing his job such that the chaplain had to do it for him. It was a situation where he had spent 20 minutes explaining to the family what the situation was and they were so predisposed to not hear him that they did not hear it, and when we restated it, then all of a sudden we were the hero. There was no real way they could see to touch me, so I was made Mr Wonderful and everybody else in the place whom they thought they could sue was Mr and Mrs Bad Person or Miss Bad Person. Just seeing the kinds of things people do and the kinds of reasons, I am convinced it would not be very long before somebody would put this to the test. People have some really funny ideas also about religion and chaplaincy and so on and so forth. That is one example, and I guess I could think of several others quite quickly, but time is limited.

The Chair: Thank you very much for your presentation.

The committee now stands adjourned. The receipt I mentioned earlier is this one at the back of the airline. It is the white piece. The clerk requires that, and the clerk has asked me to inform you that there will be four taxis at 4:20 at the front doors to take anyone who wishes to go to the airport to catch the plane. Thank you very much.

The committee adjourned at 1615.

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Professions Act, 1991
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de la santé réglementées
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Tuesday 20 August 1991

The committee met at 1003 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: I would like to call the Ontario Public Service Employees Union. The committee welcomes you. You have 20 minutes for your presentation. We would ask you to leave a few minutes at the end for questions from committee members. Begin your presentation now, please.

Ms Casselman: Good morning. My name is Leah Casselman and I am a member of the board of directors of the Ontario Public Service Employees Union. With me are Fran Zaitz, a registered laboratory technologist and an elected representative on our medical division within our union; Beverly Dalys, a researcher with OPSEU; Amani Oakley, a registered medical technologist and local president of Wellesley Hospital, and Fred Wambara, also a member of our medical division and a registered X-ray technologist.

Thank you very much for hearing our presentation today. I will try to be as brief as I can. You have our document before you, and I will be running through it. Here we go.

Our union, the Ontario Public Service Employees Union, represents more than 10,000 health care professionals across Ontario. We are, of course, very interested in this legislation. We, as many of you will know, have been fighting for years and have recognized that health care workers are dedicated professionals and that their work is very valuable to our society. We also have been trying to let the employer and the public know that these workers have been denied the respect and dignity afforded to other professions.

It is for this reason that it is a pleasure to see the government leading the way in conferring upon these workers the esteem that they have long been withheld. But we are also distressed with the line that this legislation is taking forward. The Health Professions Regulations Act and its companion acts will shake up health care delivery in Canada. The effects will no doubt be felt by many interest groups and individuals across the province. OPSEU, like other groups, has many concerns about this legislation, and

the one that we will be speaking about today in particular is triple jeopardy.

For those who are not familiar with triple jeopardy, it means that workers in the field can be actioned against by their employer, by their college and by their licensing board. When they are actioned by their employer, we have a grievance procedure, and the members, the workers, will be represented. If they are actioned by their college, they are on their own with a lawyer, and, again, they are on their own with the licensing board.

The other concerns that we will be discussing with this committee, and have discussed in the past, are the question of, again, absence of union representation on governing bodies, credentialism and the question of who gets admitted to the colleges and the financial cost our members have to bear to maintain the colleges.

We are very concerned about the discipline and that our members in health care will face this situation of triple jeopardy. As you know, the Health Professions Legislation Review was initiated in 1982 by Alan Schwartz. We have seen this as a very anti-worker bias to this committee. There was no presentation or acknowledgement or request for hearings from workers or their representative, the union.

We are not opposed to guaranteeing the public that it can rely on quality of service that the government provides. We have for some time been promoting quality public service in our campaigns, as I am sure you are aware. We become leery, however, when the burden of accountability, which properly belongs to the decision-makers such as ministry officials and hospital administrators, is passed on to the employees or the workers. Clearly, we see that this is what this bill does.

This legislation will pass on to employees responsibilities and liabilities that ultimately belong to their employers. Professional self-regulation is at odds with the work structure for many of the professions listed in schedule 1 of Bill 43.

Professional self-regulation is necessary as a check for self-employed professionals who possess a great deal of specialized knowledge and control over their work, and extensive decision-making powers. For self-employed practitioners who are in control of their work and who have no employer to determine how they will practice, it is imperative for a regulating body to set standards and step in when necessary. But for workers in traditional employment relationships who have some direct supervision in their jobs and who are responsible to their employers for carrying out the instructions they are assigned, professional self-regulating bodies may duplicate employer functions that are already carried out.

We are very aware, as I am sure the Chairperson of this committee is, of the financial constraints within the health

care system in Ontario. We are struggling daily to provide and maintain our high quality of health care within this province, but health care providers are stretched to their limits. In laboratories and hospital wards, budget cuts have forced workers to struggle to maintain that high quality. With the cutbacks, we are convinced that those burdens will shift to the workers.

The combination of financial cutbacks and increased liability through professional regulation may be deadly to health care workers. If health care professionals are brought before the council of their colleges or the health review board on a complaint, they can end up paying for their employer's shortcomings.

Unions have fought hard both in the political process and in litigation to instill the principles of natural justice into our labour relations system. When organized workers are penalized by their employers, they have access to a grievance procedure with full union representation and are deemed to be innocent until proven guilty. With the complaints and discipline procedures and bodies laid out in Bill 43, these principles of natural justice are abandoned.

1010

The triple jeopardy problem is related to union representation. The primary reason for the overhaul of the legislation covering health care workers is to make individual workers more open and accountable to the public. The bodies created under this legislation—the Health Professions Regulatory Advisory Council, which determines the scope of practice for each profession and determines who is regulated under which terms, and the Health Professions Board, formerly the Health Disciplines Board, which is primarily responsible for conducting hearings and reviewing decisions made by the councils of colleges—hold the balance of authority in the jurisdiction.

These bodies appointed by the Lieutenant Governor are charged with looking after the interests of the public. Clearly this lacks balance. In disciplinary matters, what possible incentive would the board have for finding in favour of the worker under investigation?

These bodies must be composed equally of lay public members and practising health care professionals. Without this balance, many variables which affect health care, such as technical specifications and working conditions, could be overlooked or misunderstood and lead to unfair or unrealistic decisions.

It is also important that the worker's perspective of how events may have transpired be considered in anything as important as a disciplinary hearing or in determinations on who should perform which controlled acts.

The one-sidedness that is blatant in the Health Professions Regulatory Advisory Council and the Health Professions Board is repeated, to a lesser extent, at the level of the college councils. There are a number of committees that members are appointed to, as outlined: the executive committee; the registration, complaints, discipline, fitness to practise and the continuing competence committees. These committees, which have immense control over who will be practising in each of these professions, are composed of members elected by the members of the college. On the one hand, they are public representatives of their

professions. Naturally, many will wish to represent excellence. This means they will have an interest in being rigorous with their colleagues. On the other hand, they are practitioners who have firsthand knowledge of the difficulties in the workplace and the possibilities for errors and an understanding of how their peers may be reasonably or unreasonably charged with failing to maintain the standards of practice.

Presumably, some of the members elected to the council and subsequently appointed to one of the powerful committees will be able to balance their competing interests; others might have a more biased perspective. For the council to simply appoint members to committees that can make or break a number of careers and lives indicates a gigantic leap of faith to attain justice.

OPSEU would like to see assurances built into the legislation that would make the colleges more open to its members' participation. Specifically, OPSEU would like clauses in Bill 43 which would make it clear that members elected to the professional regulating bodies are provided with paid time off with no loss of seniority from their employers for college activities. If you do not do that, you limit it to those people who can afford to participate.

For the committees and health review board to work effectively and legitimately, they must adhere to the principles of due process under law. These procedures must more closely parallel justice procedures in criminal actions, where lawyers representing both sides make decisions in jury selection, and in labour arbitration, where arbitration boards are composed of nominees representing both sides in a dispute and a neutral chair, and where a single arbitrator is agreed upon by the two sides in a dispute. Under this bill, the committees at the college level, the advisory council and the Health Professions Board do not resemble mainstream justice bodies.

To correct the problems outlined in this presentation, OPSEU recommends the following changes in terms of composition.

At the colleges:

1. The appointees of the Lieutenant Governor be selected to represent two constituencies—labour and public—and that the two constituencies be equally represented;
2. The members of council be appointed to the committees on a basis of equal representation, though the existing proportions remain the same;
3. When any committee is convened to hear a case, the public representative can select one public Lieutenant-Governor appointee, the accused can select one labour Lieutenant-Governor appointee, and that the two appointees jointly select a neutral chair from the pool of elected members.

At the college level, this setup would have another advantage. In order to be selected as a neutral chair, the elected member would have to maintain a track record of fair decisions. This would force careful consideration of all the facts. The record may also influence re-election to the college.

OPSEU also urges this committee to change the composition of the advisory council and the Health Professions

Board in a corresponding manner. It must be balanced to equally represent the two parties to any proceedings: the public and the health care workers.

We recommend that the appointees of the Lieutenant Governor on these bodies be selected from designees of the interested parties. We also ask that sections 8 and 18 be struck from the legislation. We apply the same reasoning to our position on the composition of these bodies as we do regarding the councils. Without firsthand representation of practising professionals, the advisory council and the Health Professions Board both run the risk of neither providing the public with the protection it requires nor providing the professions with the equity to which they are entitled.

The Chair: Thank you very much for your presentation. I have a question or comment from the parliamentary assistant, Mr Wessenger.

Mr Wessenger: You make a statement that I am somewhat concerned about. You indicate that the discipline procedures are contrary to the principles of natural justice. I would like you to elaborate on that statement, because I would like to know the specifics you have concern about.

Ms Dalys: I am Beverly Dalys, research education officer with OPSEU.

The principles of natural justice involve, among other things, equal representation for two sides. There is no representation for workers at any level. If you have the Health Professions Board having solely representation from the public and it is deemed to balance the interests of the public against the interests of the health care worker, there is obvious lopsidedness there. Where is the worker's representation or representative?

The legislation states that the Health Professions Board can hire consultants who know health care, but those people are not going to be practitioners. Those people are going to be former health care workers who might not be in touch with the realities in the health care settings today, which are undergoing a lot of change because of budgetary reasons. They are generally we think going to be management people who have gone on to the next stage in their career and are really quite removed from the reality, or workers, in the health care system. Certainly when we compare any of these boards we have talked about and the councils in the colleges to arbitration boards, they are quite different. I think the question of where natural justice is missing is quite evident when we look at that.

Mr Wessenger: You have no specific suggestion with respect to procedures under the act or no complaint about procedures. It is really just a question of representation on the college discipline board. Is that your only concern?

Ms Dalys: Representation is our primary concern. I can get back to you in writing with more details on procedure. It is not something we have consulted our membership on widely.

Mr Wessenger: I would just like to make a comment. I think you are looking at a traditional labour situation where you have a board composed of management and employee representation equally with an independent arbitrator,

but I assume that is not the type of structure you are looking at with respect to this committee. You are not going to have management people on that committee. Therefore, you know, it is just like a judge. A judge gives justice, and an independent board—I do not see the problem with respect to this whole question of natural justice in this regard.

Mr Martin: Just listening to your presentation, I wanted some clarity. You mentioned that you would like to have five labour and five public on the appointed side of the college. Presumably you mean labour from the particular group of people the college oversees. That, in my mind, would tip the balance of the committee in a direction that was different from the intent of the legislation, which was that there would be just a slight overrepresentation of the college, of the professional versus the public. Could you explain that a little further so I might understand it more clearly?

1020

Ms Dalys: Okay. When you are saying this, are you talking about the amendments that were brought in about two weeks ago with respect to the colleges?

Mr Martin: No. Your recommendation this morning here that says, "The appointees of the Lieutenant Governor be selected to represent two constituencies: labour and public." The intent is that it would be the public. You are saying labour and I am asking, do you mean the folks the college is overlooking? If so, then that means the balance is tipped in favour of having certainly many more of the profession in the college than the public. The intent here was to keep that a little closer so that we would have more protection for the consumer.

Ms Dalys: We mentioned in the presentation that we think the elected members to the colleges have quite an opportunity to be neutral because they represent excellence in their professions, they know their professions, they obviously want the public to look upon them favourably. They also recognize where there may be difficulties in the workplace settings, where cost-cutting might mean they are forced to compromise their standards of practice. We seem to see some balance there, but when you bring appointees in from the public, they are going there to determine someone's fate, and if there is no pressure on them to say, "What's the balance?" they can say: "Better safe than sorry. Destroy this person's career because he may have made a mistake."

We do not see where the public representatives, if they represent only the public, which is trying to be protected from the health care worker, assuming it needs this protection—we do not see a balance there. If your public members are looking at both sides of the problem, and one is, "Is the public being adequately protected from whatever may happen in the health care system?" and, "Is the worker really at fault?" I think that is where you get the balance.

Mr Martin: My reading of it is that if you put five, the profession then gets two shots at being on the board and the numbers then become greater. Anyway, I understand what you are saying.

Mr Beer: This really follows on with the question we just had, but I ask you to really think through what you are proposing here. It seems to me if I am a member of the public and am appointed, part of my responsibility in protecting the public interest is very much in looking at the concerns individual workers may have and in achieving that balance. The whole reason for public participation is to look at the whole broad spectrum of public interest.

It seems to me that what you create here is a further problem. I put it to you that part of the responsibility as a public member is ensuring that the interest of the worker, the professional, whoever it is who is coming before the body, the council or the college, is protected. You seem to juxtapose the interests of labour and the public as though they are two entirely different things.

Ms Casselman: Not at all. We just want to make sure that both sides are equally and fairly represented. That is why we would go to the model of an arbitration where you would have both sides representing, to ensure that the the cost-cutting factors that have affected the way this person can now do his job are presented; or these are the changes this local employer has implemented in this procedure, which may not be under the act, so he can get the job done faster.

We just want to make sure that someone from labour, representing the worker, is presenting the whole case fairly. We are not in any way negating the responsibility or the importance of having the public there at all. It is not a matter of trying to shift the balance. That is why we would see that neutral chair in there. It is a matter of ensuring that all the factors that affect the way a worker is told to do his job by an employer—because we are talking about an employer situation. Those are the things we want to ensure are there. We do not think a public member would have access to that knowledge or that understanding.

The Chair: I would like to thank you very much for your presentation before the committee this morning. We appreciate your appearing. I say to you and to any members of the public or professions that if at any time over the course of these hearings there is additional information you would like to present, please feel free to do so in writing.

CANADIAN INSTITUTE OF PUBLIC HEALTH INSPECTORS (ONTARIO BRANCH)

ASSOCIATION OF SUPERVISORS OF PUBLIC HEALTH INSPECTORS OF ONTARIO

The Chair: I would like to call now the Canadian Institute of Public Health Inspectors (Ontario Branch) and the Association of Supervisors of Public Health Inspectors of Ontario. I ask that you please introduce yourselves. You have 20 minutes for your presentation. I ask that you begin now, and if you would leave a few minutes at the end for questions from committee members, we would appreciate that.

Mr Callanan: Thank you. My name is Paul Callanan and I represent the Canadian Institute of Public Health Inspectors (Ontario Branch). Pamela Cook represents the Association of Supervisors of Public Health Inspectors of Ontario. Klaus Seeger is the president of the of the

Canadian Institute of Public Health Inspectors (Ontario Branch).

Thank you for this opportunity to address you on Bill 43. The purpose of our presentation is to affirm the interest of public health inspectors in being designated under the legislation. It is our understanding that from the outset the primary purpose of regulating health care professionals was to advance the public interest by protecting consumers from unqualified, incompetent or unethical health professionals. Public health inspectors are currently unregulated. It is our position that this is not in the best interests of the citizens of Ontario.

Our submission details briefly the role of the public health inspector, education requirements, the need for and benefits of public health inspector registration and registration in other provinces. We will try to be brief and, in the interest of time, we will perhaps skip over a few sections in our brief.

Contemporary preventive health care is a highly complex, multidisciplinary system. Public health inspectors act independently in fulfilling many diverse program responsibilities, and their supervisors must rely on their sound judgement, integrity and competence as they serve the public in a myriad of ways each day. Designation and establishment of a college would assist program directors and the medical officer of health in providing the highest quality of service to the public.

In 1989, a national study of the profession established that the national percentage of public health inspectors were monitoring or advising with respect to a wide variety of environment health program areas, some of which are listed in our presentation.

At appendix A, you will find a generic job profile for a public health inspector, as prepared by the Ontario branch of the Canadian Institute of Public Health Inspectors.

Citizens place their health, and often their financial security, in the hands of the public health inspector when dealing with problems such as contaminated water, unwholesome food, food poisoning investigations and various land development issues. The citizen cannot be expected to know if the advice is correct or if the public health inspector is competent and acting ethically. The difficulty the public has in screening practitioners—and the same difficulty faces employers—increasingly imposes an obligation on the part of the profession to ensure that minimum standards of conduct and competence are maintained, but in order to do so effectively, however, professions must be legally mandated.

Subsection 26(1) of Bill 43 provides that:

“No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,

“(a) the person is a member authorized by a health profession act to perform the controlled act.”

Subsection 26(2) goes on to list controlled acts, one of which is “communicating to the individual or his or her personal representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms.” It is part of the job of a public health inspector to “communicate a conclusion identifying a disease, disorder

or dysfunction as a cause of symptoms," and it is certainly foreseeable that the conclusion will be relied upon by the client. A few examples include food-borne and water-borne disease investigations, communicable disease follow-ups such as bacterial meningitis, and infections resulting from drinking contaminated well water or swimming in contaminated water.

The public health inspector might indicate, "You had food poisoning caused by salmonella enteritidis," or, in another example: "The lab report indicates your well water is contaminated. Your symptoms result from drinking contaminated water." Yet another example is, "It is possible that you contracted conjunctivitis from swimming in a pool with unchlorinated water." In each of these examples, members of the public relying upon the information provided by the public health inspector are exposed to harm if the information is in error.

In addition, physicians often refer their patients to health units and public health inspectors when they suspect a patient's symptoms may result from environmental exposure. Examples include blood lead level studies, methaemglobinaemia investigations and carbon monoxide exposures. An incomplete investigation in any of these cases poses a significant risk of harm to the patient.

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Sanctions for the offence of performing a controlled act contrary to section 26 include fines of up to \$25,000, imprisonment or both. Public health inspectors are justifiably concerned about their potential liability. Moreover, since public health inspectors perform controlled acts and since there is a risk of harm resulting from the performance of these acts, public health inspectors should be designated in order to protect the public from harm.

Education requirements: The current requirement to practise as a public health inspector in Canada is certification by the Canadian Institute of Public Health Inspectors. Certification follows university education, an apprenticeship period and successful completion of oral and written examinations. Continuing education is an essential part of the life of a professional person. Once practising, there is no requirement that the public health inspectors in Ontario maintain minimum standards of competence, however. Public health inspectors who received training many years ago may not be adequately familiar with changing technologies and new health issues.

In addition, certified inspectors may re-enter the profession after an absence of many years without adequate retraining. We maintain that the public is not well served by a system that does not ensure that public health inspectors, in addition to other health professionals, are trained to current standards. The field of environmental health is complex and rapidly changing and a requirement for continuing education should be enshrined in the profession. The Canadian institute is not currently mandated to require continuing education for its members, but designation in Bill 43 would allow standards of continuing education to be established by the college.

Ms Cook: Turning to the need for registration, it is our belief that designation of public health inspectors is

necessary to protect the public from harm resulting from this conduct. A number of examples of public harm were discovered during preparation of this position paper. In one case, a public health inspector issued a number of certificates of approval to construct private sewage systems which were contrary to requirements of the subdivision agreement and the Environmental Protection Act and regulations. Each applicant was directed to deal with one particular contractor, who allegedly extended financial rewards to the inspector for the business.

In another example, a public health inspector who also owned a private business allegedly used confidential information gained from public duties to arrange contracts for his business. He also allegedly issued approvals contrary to the regulation in return for personal benefits. In another case, a public health inspector routinely coerced a restaurateur to cash cheques, all of which were returned NSF. The restaurant operator permitted a number of NSF cheques, being concerned about reprisals by the public health inspector if he reported the inspector. Unfortunately, there are other examples.

In some of the cases of misconduct we uncovered, the inspectors were dismissed once the malfeasance was brought to the attention of his or her employer. This does not, however, prevent employment as a public health inspector with another agency and the possibility for further public harm.

Without disciplinary authority or procedures, the Canadian Institute of Public Health Inspectors is powerless to control its eligibility for rehire. The public deserves the right to independent investigation of public complaints regarding public health inspectors. The field of environmental health and the role of the public health inspector have changed significantly in recent years, and their certification by the Canadian institute, which is required to practise as a public health inspector in Canada, is insufficient to regulate the conduct and competency of a public health inspector once practising.

The self-regulation envisioned by Bill 43 would allow establishment of a system of continuing education which will ensure that only competent public health inspectors practise in Ontario. In addition to health care consumers, employers in the public health inspection profession would also benefit from designation. Employers would benefit from a system designed to strengthen the abilities and competence of existing staff and ensure the competence of new employees who may have been working in other fields for a number of years.

Formalized standards of practice and a code of ethics would also assist the employer in establishing expectations of employees. If designated, the public health inspection profession would also benefit from a new-found ability to deal effectively with complaints of misconduct or incompetent practitioners who may cause the reputation of the profession to fall into disrepute. The impartial review process contemplated by the legislation would provide for a thorough review of any complaints while at the same time protecting members from frivolous and vexatious allegations. Members would also benefit, through greater

employee support for continuing education, to maintain minimum standards of competence.

Turning to registration in other provinces, Bill 43 provides Ontario the opportunity to show leadership by designating public health inspectors, thereby requiring self-regulation with appurtenant public benefits. Other provinces, however, have already granted self-regulation to public health inspectors. By a 1985 amendment to the Society Act of British Columbia, registration was granted to public health inspectors.

A board of registration which is affiliated with, but acts autonomously from, the CIPHI British Columbia branch, is empowered to administer all matters respecting the registration of members, including qualifications for membership, continuing education, conduct of members, ethics and standards of practice and sanctions of misconduct, including suspension or expulsion from the membership. The BC branch has developed standards of professional practice which are outlined in appendix B. Similarly, legislation has already been passed in Alberta, and public health inspectors in Saskatchewan and Quebec have requested registration, and it is presently under consideration in Manitoba, Newfoundland and Atlantic branches of the institute.

The Health Professions Legislation Review criteria were developed to address four basic issues. While the Ontario branch of the CIPHI addressed the four criteria in our 1984 submission to the Health Professions Legislation Review, we found it may be useful to review our position in this paper, and these have been outlined for you in appendix C.

In conclusion, public health inspectors are key players in the increasingly technical world of health care. They are part of a team but do not share the same protection as other members of the team. Consequently, the public cannot be assured that all practitioners they come into contact with have met with the same minimum standards. Designation of public health inspectors is necessary to ensure that the public has access to competent and professional public health inspection services.

Inclusion in the health professions legislation will bring benefits to the following: The public will be better protected through a system designed to ensure the ongoing maintenance of competence of public health inspectors it turns to for advice and guidance; and inclusion in the legislation will ensure the highest standard of service to the public. The employer will benefit from a system designed to strengthen the abilities and competence of public health inspectors. The employer benefits from a system which ensures it a constant supply of well-qualified, competent, professional staff. Further, when problems such as incompetence or unethical behaviour arise, the employer is assisted in dealing with these. Professionals benefit through the support and guidance they receive regarding maintaining their competence and adherence to established professional standards. The profession will benefit from a system which permits unqualified, unethical or unscrupulous practitioners to be suspended, penalized or even barred from practicing. The ability to regulate the public health professional

helps to protect the health and safety of the public by setting standards for education, training and practice.

Mr Wessinger: Thank you very much for your presentation. Are you aware that under this act there will be a health professions advisory council created to which you can apply for designation?

Ms Cook: We are aware of that.

Ms Haack: I definitely appreciate the kind of work you do out in the field, which basically is the foundation of my question at the present time. As a public health inspector, in most instances, would a physician be referring a situation to you for investigation, or what is the process by which you would be doing your examinations and investigations?

Mr Callanan: In most cases, programs are specifically mandated under the Health Protection and Promotion Act. Mandatory programs dealing with areas such as food safety, water supply, communicable disease control, etc are very specific to public health inspectors. In other cases physicians, the medical officer of health, associate medical officer of health or, more often, private physicians refer patients to the health unit and public health inspectors for assessment of environmental exposures. I would say that, in comparing the two, the bulk of our work is mandated programs.

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Ms Haack: You are going in to look at restaurants, or you might have received a complaint from the public, but in other instances it is just part of your regular inspection program. When you made the comment about providing a diagnosis or an assessment whereby someone might have food poisoning caused by salmonella—and I will leave the rest of the description to you—or when you were saying, “Your symptoms are the result of drinking contaminated water,” would that then be under the bulk of the points of those situations where you would be making those examinations? Would somebody be going to you directly, or would the person have been referred to you by his or her doctor?

Mr Callanan: Generally they would contact us directly. Those would be complaints situations such as: “I ate in X restaurant and was sick. Would you please check it out.”

Mr J. Wilson: Under current circumstances, has your institute thought of any way of decertifying public health inspectors for misconduct, or some of the cases you brought forward as examples of misconduct, for instance?

Ms Cook: No, we do not.

Mr J. Wilson: None whatsoever?

Ms Cook: Once you are certified, you are certified for life. That is what we are saying; we are unregulated and we would like to be regulated to give us the authority to deal with those types of instances.

Mr J. Wilson: I see in the appendix of BC examples of codes of practice there are no teeth to enforce those.

Ms Cook: Not at this point in time.

Mr Seeger: In addition to that, if I wish, I can leave the field for 10 years, come back in 10 years and find

another job within a health unit. There is no mechanism in place right now to find out if I am still up to date. There is nothing to control that and that is where we see being designated as a way of at least requiring that person to become up to date.

Ms Cook: There is presently a 7% national vacancy rate of public health inspectors across the country. We are concerned that more desperate health units will hire inspectors within other fields for longer than five years. There have been many instances, and it is incumbent upon that health department to retrain those people, but we are concerned about their competency starting out. We are not convinced that every health department has taken it upon itself to retrain people properly.

Mr J. Wilson: I notice in the brief that one of the reasons the review board did not feel it was the time to include you in the act was that there were not documented cases of serious harm. Have you made strides in documenting those cases? You mentioned some today.

Ms Cook: Yes, there are several country-wide now that we do have.

Mr J. Wilson: You should have a good crack at it in future.

Mr Hope: I was looking over the job descriptions and I guess there is the certification of public health officers. Do you not work on a broader aspect dealing with environmental acts, water acts or whatever they may be? Are you working on a broader scope? I am not sure where the health professions regulations all come into place. I am trying to get a better understanding of exactly what you are doing. Are you upholding laws, food standards and whatever else? I am really not sure where it comes into play with the health professions.

Mr Callanan: Most of our work is mandatory programs under the Health Protection and Promotion Act, in essence dealing with health hazards: What is a health hazard? What may be a health hazard? Taking action to mitigate or eliminate health hazards. Regulations such as the food premises regulations are enacted under those types of provisions. In our estimation, diagnosing what is a health hazard and what is not a health hazard is where we fit into Bill 43. If we make an error in judgement, for example, during a restaurant inspection, by not condemning food that has been left at room temperature for a period of time that contains pathogenic bacteria and someone gets sick as a result of it, the error in judgement of the public health inspector affects the public.

Mr Hope: So you are not diagnosing the individual; you are diagnosing the product or the area that you are concentrating on. You are not diagnosing the individual as having food poisoning, but you are diagnosing the area you are focusing on.

Mr Callanan: In that particular case, yes. In another example the person would call us and say: "I think I was ill as a result of eating in this restaurant. Would you please investigate?" That is where we would diagnose food poisoning.

Mr Hope: Would they not go to a doctor first to find out why they were ill and the doctor would say, "You have

food poisoning," and then call you and say, "Check that restaurant out"?

Mr Callanan: The doctor does not normally call us in a situation like that. Normally the person would call us first. Sometimes they would call their doctor and the doctor would say: "Call the health unit. I have no jurisdiction over restaurants." In cases like that we would take specimens from both the person and food samples from the restaurant, and the diagnosis would be based on the results of those laboratory reports.

Mr Hope: Would that be on the order of a doctor?

The Chair: I am sorry. Is that a serious question to the parliamentary assistant?

Mr Hope: Yes, because I would like to know, if a doctor says it is out of his jurisdiction and refers you to a public health officer, would that be on the order of the doctor?

Mr Wessenger: I will ask staff to answer that.

Ms Bohnen: I think it is unlikely that the physician is actually delegating to the public health inspector the responsibility to diagnose what is wrong with the patient who is complaining of various symptoms, in terms of identifying a disease that is causing this patient's symptoms. That situation described, where somebody calls up and he has various symptoms and the patient suspects it is related to eating particular food in the restaurant, and then the inspector obtains samples from both the patient and the restaurant and then discovers the bacteria and draws a causal connection between the two, is not a diagnosis captured by this legislation.

The Chair: Thank you for your presentation.

ONTARIO AMBULANCE ASSOCIATION

The Chair: I now call the Ontario Ambulance Association. Please introduce yourselves. You have 20 minutes for your presentation. We would ask if you would leave a few minutes at the end for questions. Please begin now.

Mr Moir: My name is John Moir, and this is my colleague Rob Wright. We are here to represent the Ontario Ambulance Association.

I will just give you a little bit of background on myself so that you can understand my qualifications and why I am here. I have been a practising paramedic for the last six years. I have been an ambulance officer in Ontario for 14 years. During those years I have been an auxiliary training officer with the Ministry of Health. I have been an examiner for the Ministry of Health. I have also served on the air ambulance program, flying out of Timmins, servicing northern Ontario.

I have also been president of the Canadian Society of Ambulance Personnel, a national professional body for ambulance officers, and the vice-president for the former Association of Casualty Care Personnel, a provincial professional organization. For the last five years I have been publishing a national academic journal called *Emergency Pre-Hospital Medicine* for my colleagues across the country. I am presently chair of the steering committee for the formation of the Ontario Ambulance Association.

That said, you realize that this process is probably one of endorsing the groups that have already been admitted under the pending Health Disciplines Act. We are here to make an appeal to include the ambulance profession and, if that is not possible, then to present or promote the idea that the process be accelerated, once the legislation is passed, to quickly include this group. I do not feel that by excluding the ambulance profession the public has been served at all. I believe that it has not been in the best interests of the general public at all.

When I think of what my colleagues do in the field, I am dismayed by the fact that we are not included. An ambulance officer—there would probably be two; generally there always are two—would be responsible for responding to a scene. It may be a high-speed motor vehicle collision. It may be a medical emergency in the home. If it is a two-car accident, for example, and depending on the location of where this accident or illness may occur, there may be a level of service from a very basic level, such as a volunteer body that has basic first aid, CPR, or right up to what we refer to as advanced life support, which is basically a direct extension of the emergency department to the community.

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These individuals are responsible for assessing the scene, assessing safety, providing initial patient care, making provisional diagnoses, treating those patients based on that judgement, co-ordinating with allied health care people and updating the emergency department. The level of care they would provide could be anything from intubation, which is introducing an airway tube into the trachea, to providing intravenous solutions. It may be cardiac medication or basic spinal immobilization.

There are a number of basic medical procedures that can be carried out. Personnel may be under direct supervision of a physician or they may just be providing this level of procedures through standing orders that, if they recognize and diagnose the patient as having such and such, they will go ahead and perform a number of procedures before they contact the base hospital physicians.

With the way the advanced life support programs have been developing in the province over the last five years, there is not one consistent program from one centre to another. The government has been developing a system based on a modular approach, based on community needs as it identifies them. I am quite concerned because I do not believe the communities' needs are being addressed appropriately.

We do not have a recertification process in the province to ensure that the standards are maintained. I am also concerned about the fact that the government provided in the Ambulance Act, a document that covers financial management, vehicles and equipment, very little in the way of training standards. I am concerned that, again, the public's safety and best interests are not being met.

On the idea of recertification, the logic escapes me that funeral directors have to be certified, for example, every five years, and they are dealing with the dead, whereas our profession is still dealing with those who are with us, and we do not have those requirements.

With the advanced life support programs, ambulance officers, in consultation with their base hospital physicians, are pronouncing death in the field, and at that point they are helping the families with the initial grieving process. Since we first made our initial submission to the committee back in 1983, a lot has changed. As you can see, in 1983 we did not have advanced life support. In fact, ambulance services in the province have accelerated greatly since that time.

There are a number of developments that may take place in the future, such as antithrombotic therapy or interosseous infusion, which is basically sticking an intravenous needle into the bone marrow of a small child to administer solutions. There is another procedure we call transtracheal jet ventilation, which is sticking yet another needle into the windpipe of an individual to help him breathe that way. As well, there is further development of the air ambulance system. All these pending new procedures on the horizon not being included under the Health Disciplines Act, again, I think is a grave omission.

I find the union involvement at present a bit threatening because if the general public have a complaint with regard to the duties of an ambulance officer, they would go to one of, I understand, four investigating officers in the Ministry of Health or emergency health services. Four people to investigate a province of this size is greatly understaffed. It then becomes a disciplinary function, which then, I believe, goes between the union negotiations and management negotiations, and there is no real penalty for the individual.

As an example, if we had certification and were included under the act, similar to the medical profession, the professional body would investigate. If it were deemed that the malpractice had indeed occurred, then you could administer a penalty, and it would take it out of the hands of union involvement and take it out of the hands of direct management involvement. For all those reasons, I just cannot understand why the original submission was not entertained.

In closing, if there is no access to an appeal process to be included before third reading, then I hope the process will greatly accelerate to include this group in the future review.

Mr Hope: Looking at your presentation and looking at Bill 43, under the legislation ambulance attendants are not held back from performing their jobs.

Mr Moir: I am sorry? Say again.

Mr Hope: They are not held back from performing emergency jobs.

Mr Moir: No. Right now what happens is you have two individuals who are basically individual practitioners. There are two people, a crew, that respond to a call. There is no supervision. There is no supervision from any medical organization. In the hospital you have a nurse who is obviously under the health disciplines body. She or he may have great amounts of resources to draw upon. They have the medical community within the hospital; they have laboratory services; they have everything, as well as supervision.

The ambulance officers in the field—it may take a half-hour from the station to respond to a call—are the

only ones who are responsible for initiating medical treatment and transportation.

Mr Hope: But they have communications with the hospitals and emergency rooms.

Mr Moir: No. In Toronto, for example, we have an advanced life support program. There is direct consultation with the emergency room physician, a physician who is trained in emergency medicine.

In smaller centres the hospital emergency room may not be staffed by an emergency physician. Most likely it would be a general practitioner who may or may not have additional training in emergency procedures. Emergency medicine is, in my mind, a mindset. It is training you to act quickly, giving you a number of resources, certainly the experience of working under that high-pressure environment.

It is, I find, a very unstable environment out there. If it is a motor vehicle accident, there are a number of other associated dangers. If it is in the home, it is just those two ambulance officers and the patient and the patient's family. As you can appreciate, when a patient is brought to the emergency room, he is brought out of that unstable environment. They are under bright lights, the family is usually separated, or loved ones.

You must appreciate when these ambulance officers work in that kind of environment they have the emotional distress of the family, in a sense, pounding on their shoulders. So you not only have to look after the patient or a number of patients, you also have to look after the family members.

Mr Hope: Just under the Ambulance Act and regulations—and you talk about the physical strains, you talk about the issue of training and certification. Would that then not fall under that act? I am not well versed on the act so that is why I am asking the question. Would you not address those concerns you have raised in your brief under the act?

Mr Moir: First of all, certification was set by the emergency health services, in consultation with other groups, in all fairness. It was not set solely by the people who practise in the field. Those standards initially were set as entry-level certification. If you have been practising in the field for five years there is no mandatory recertification; there is no mandatory continuing medical education where there is an ongoing process.

You can appreciate, if you are responsible for responding to a multicar accident or a paediatric emergency or trauma, if you have not had one of them in several months, how good are you going to be in the sense of responding quickly, making the appropriate decisions, if you do not review that information on a consistent basis? That is why we have trauma centres, where we have physicians who are certified in emergency medicine. That is a specialty. That is all they do. That is why we do not have emergency physicians or trauma centres spread out in every hospital in the province; the volume is so low. So it is hard to maintain skills.

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Mr J. Wilson: I have a question for the parliamentary assistant. Could we have explained to the committee why

the Health Professions Legislation Review committee did not see fit to recommend this group for registration at this time?

Mr Wessenger: I will ask ministry staff to respond to that.

Ms Bohnen: I believe the reasons were twofold. First, the invasive and other high-risk procedures performed by ambulance personnel are sanctioned medical acts, and the qualifications to perform them and the requirements for direction and supervision are provided by physicians. Second, the Ambulance Act and regulations, imperfect though they may be, provide a structure for regulation, provide a structure to ensure adequate qualification and safety in the provision of ambulance services.

Ms Haeck: In light of the fact that you have the additional Ambulance Act—and I realize that we are going more and more to the pre-paramedic mode—is there an inclusion of the paramedics under the Ambulance Act or has that been handled through regulation?

Ms Bohnen: I am not expert in the Ambulance Act, so I cannot really speak to that. What I can say, though, is the high-risk procedures that are performed by ambulance staff, including paramedics, are dealt with in some detail in a document called Sanction to Medical Acts, which is prepared, if I understand it, in consultation with the College of Physicians and Surgeons of Ontario, ambulance authorities and so forth. It sets out what activities may be performed in what circumstances, what kind of linkages have to be maintained with physicians and so forth under their provision.

Mr Moir: The physician body is part of the certification process for advanced life support, no doubt about that. The pilot program that we had was taught by ambulance officers to ambulance officers, with a supervisory overview by physicians. Certainly the one that gave the final endorsement was the physician body. But these acts are taught by my colleagues using mannequins and other educational devices.

But out there, once you are certified as being at a certain level, these acts are carried out by ambulance officers. It is no different from nurses being sanctioned by the college of physicians and surgeons where there are invasive medical acts. When I think my daughter or my own family could be involved in an incident where they would need the same type of high-level care, it concerns me that we do not have the same type of legislation that is available to control the medical profession, the nursing profession. I see the midwives are included. We do emergency childbirth in the field.

So it just confounds me, the fact that we were overlooked initially, because our document really has not changed. The roles have changed. The purpose of this process, I believe, was to take a look at the needs of the public in the future, not in 1983. The process was to take a look at what the needs for the public were 10, 20, 30 years down the road. As you can see, this profession has accelerated. There is still potential to accelerate, not only in more procedures, but certainly to move across the province in greater numbers. Alberta has been very progressive. They

moved, and their ambulance profession is legislated in their health disciplines act.

Mr Martin: Just a comment or question on the evolution of delivering health care in our province, certainly in areas like northern Ontario, where the ambulance becomes so much more a critical part of the delivery of health service. In Sault Ste Marie right now, we are looking at a base hospital that depends very much on the ambulance. You are aware that there is provision for you to apply to the advisory council once this piece of action is over so that you might become regulated. After having heard you today, I would very strongly suggest that maybe you do that. Maybe you might want to comment a little bit more on what I have just said re the base hospital phenomenon.

Mr Moir: I am not sure the base hospital process is the best solution. I see that only if there is a professional body in Ontario. I see that the reduction reduces the health care cost because it is being borne by the individual. Certification is borne by the individual. Recertification costs are incurred by the individuals as they recertify. I am really not sure why it was overlooked, other than it must have been something behind the scenes, because it is very important to what we do.

As I said earlier, our purpose in coming here today was a small possibility that a last-minute, last-ditch effort would somehow be squeaked under the wire; then fine, that would really make us happy. We really did not believe that, but we wanted to go on record with our position that we are just dumfounded that our group was not included and to appeal that the process be greatly accelerated for our group, so that once this part of the process is completed, then the ambulance profession in Ontario will be included in the Health Disciplines Act.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee. As our hearings progress, if at any time you feel there is additional information that would be helpful to the committee, I encourage you to send us your comments in writing.

Mr Moir: I did bring some copies of our academic journal. I am not sure if it is appropriate, but I thought if members of the committee wanted to look through it, it really does encapsulate where the profession has gone in the last five years that we have been publishing.

TORONTO ART THERAPY INSTITUTE
ONTARIO ART THERAPY ASSOCIATION
CANADIAN ART THERAPY ASSOCIATION

The Chair: I now call the Toronto Art Therapy Institute. Introduce yourselves to the committee. I believe the Canadian Art Therapy Association and the Ontario Art Therapy Association are also part of the presentation. You have 20 minutes for your presentation. We would ask that you leave a few minutes at the end for the questions from members of the committee.

Ms Grossman: My name is Gilda Grossman. I am the senior art therapist with the Toronto Art Therapy Institute and president of the Ontario Art Therapy Association. I am

connected to the Canadian Art Therapy Association. I am associate editor of their journal.

Ms Merkur: My name is Barbara Merkur. I am an art therapist in private practice. I am also the membership chair of the Ontario Art Therapy Association.

Ms Grossman: In your packets we have included information about the training program at the Toronto Art Therapy Institute. It is the blue brochure and the thick white one that begins, "Dear prospective applicant." The submission from the three organizations is the copy beginning "Submission." Letters of reference from psychiatrists, nurses and executive officers of community agencies: We have three from physicians at Sunnybrook Medical Centre and the head nursing manager at the Wellesley Hospital and three other letters from Bloorview Children's Hospital, from Baycrest Hospital and from the Barbara Schlifer Commemorative Clinic on the work of art therapy, just for your reference.

Art therapy is a well-established method of treatment in the United States. It is about 50 years old there. There are over 50 universities that grant the master's degree. Five now have granted PhD in art therapy. Their professional association numbers in the thousands.

It is achieving recognition in Canada and Ontario. Graduates of art therapy programs are being employed now in hospitals, social service agencies, schools, community centres, mental health facilities.

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When the initial survey was done years ago to decide whether art therapists could be included in the act, the team could not predict the growth of the profession, the responsiveness of other mental health professionals to the use of art therapy. At that point, it was decided that we were not going to be included in the act, in that we could not regulate ourselves. I can understand that then, but since that time, many things have changed. I think we are at a point where we can regulate ourselves, and in fact, members of the national organization are able to have liability insurance, and do so not only as members of a team but as private practitioners.

This legislation would seriously impede the use of art therapy as a highly beneficial and cost-saving intervention. Our experience is that the length of treatment time can be significantly reduced through the use of art therapy as part of a team approach and part of treatment. Populations with special needs, such as delinquent youth, children who have been sexually abused, children and adults with chronic physical and emotional needs, respond well to art therapy in a way that they cannot respond to verbal therapy.

The non-verbal aspect of art therapy permits freer expression of issues which are both past as well as recent ones which are difficult to impossible to access verbally. We have letters at our institute from women who were sexually abused or victims of incest who have commented that without this intervention, they could not hope for the healing that has taken place.

Art therapists have worked at many hospitals in Toronto through the province—Bloorview Children's Hospital,

the Hospital for Sick Children, Doctors Hospital, Toronto General Hospital, Sunnybrook Medical Centre, St Michael's Hospital, Mount Sinai, Thistletown Regional Centre, Humber Memorial Hospital, Whitby Psychiatric Centre, Wellesley Hospital, the Clarke Institute of Psychiatry, Penetanguishene General Hospital and other settings—where information elicited through an art therapist on the team contributes to a refinement of the diagnosis and helps with treatment planning.

The contemplated legislation would limit our effect in this and freedom to work with clients. This would be counterproductive to the purpose and meaning of therapy. In spite of having received specialized training in education, in the theory and practice of art therapy, there would be considerable apprehension about the possibility of being held criminally responsible by encouraging the patient to share his or her suffering with a professional art therapist, and that is the chief healing.

In terms of professional standards, the institute was established in 1968. We are the oldest training program in Canada. We were established in 1968 by Dr Martin Fischer, who has used art therapy—he is a psychiatrist—in this province since 1944 at the old Lakeshore hospital. He has been an outstanding pioneer in the field of mental health. In 1989, the Ontario Medical Association awarded him the Glen Sawyer award for his contribution to the community. He is also the founder and first president of the Ontario Group Therapy Association and the Canadian Art Therapy Association. He is a life fellow of the American Psychiatric Association and the Canadian Psychiatric Association, a fellow of the American Group Psychotherapy Association. He is internationally known for his work and he has been invited to speak in Canada, the United States, Holland, Israel, Norway and South Africa.

Both Barbara and myself are graduates of the Toronto Art Therapy Institute. Our institute follows guidelines established for training by the Canadian Art Therapy Association and currently, as members of the executive of the Ontario Art Therapy Association, we have been working actively to promote and maintain standards on a provincial level.

Our training is extensive as art therapists. Just to summarize it for you, we have to undergo at the Toronto Art Therapy Institute 530 hours of class time—this is after a BA—700 hours of internship time and, in addition, all of us must go through 80 hours of personal psychotherapy with a qualified psychotherapist in the community. These again are guidelines set by the Canadian Art Therapy Association.

Our recommendations is, we would like you to include us in the legislation and to promote and facilitate the use and contribution of art therapy to the spectrum of available therapies in the province. The integrity of the profession of art therapy is safeguarded by guidelines utilized for the establishment of training and practice in Ontario which conform to standards established by the Canadian Art Therapy Association. We are the oldest art therapy association in Canada. The Canadian association publishes a scholarly journal biannually and has held an annual conference for 12 years, as well as regional conferences.

Mr Beer: Thank you very much for your presentation. I think what is particularly interesting here is seeing, while in your terms a reasonably old profession, I think for a lot of laypeople one we are not as familiar with.

In art therapy, and music therapy, which increasingly is being used as well, your sense is that in terms of your own organization, you would be ready today to become self-regulated in the same vein as the other organizations.

One of the difficulties, you will appreciate, with the legislation is that it has taken a long time to get to this point. There is a provision where there will be an advisory council, which is going to look at, for example, the naturopath question. Is that something that would be acceptable as well, if this was put to the new council? They are going to be looking new bodies before we do.

Ms Grossman: Yes, it would. I think that sometimes committees are not aware of all the trends that can exist, and if you learn from the United States, if it takes off in the same way, which I am sure it will, some of that will be part of typical treatment. So yes, very much so.

Mr Beer: At the present time, in your work, would it be fair to say that you always perform your work as part of the team or directly with a psychiatrist or psychologist?

Ms Grossman: The majority, but there is always the percentage of professionals. Just as in social work or in psychology, once they attain a certain level of expertise, they do begin private practice.

Mr Beer: And you may practise privately without other restrictions?

Ms Grossman: You have to be part of a registry. Part of it is—and this is something that I think is important—if the standards correspond to the national body, you can call yourself a registered Canadian art therapist or a registered provincial art therapist. Then you would be part of that registry, and you would have had to complete X years of training and X years out in the field. That is why we included that paragraph in terms of our standards that we wanted to see go on record as ones that should be established.

Mr Hope: Just as you are looking for self-regulation, and in the meantime, as Mr Beer has indicated, the advisory council—taking that away, if the legislation gets passed, would there be jeopardy of you performing your job? I have been listening to some of the conversation. You work in co-operation with the psychiatrist, which is usually by reference. Usually, a psychiatrist cannot communicate with the individual or get the feeling out of the individual, so then it is referred to you, where there is a way of expression. That will still happen, will it not, though, under the regulations, because you will have the ability to communicate with the psychiatrist who has been examining the individual?

Ms Grossman: I think it will curtail your interaction with the client or the patient and he or she will pick up on it. If the legislation goes through—I think it is in the paragraph—anything you say is going to be heard and might be commented on in a certain way. It is going to curtail your freedom to interact.

Mr Hope: Yes, but the recommendations I guess then that the unregulated practitioners are making to the issue of communication—if we took a look at that communication, would that then help?

Ms Grossman: I guess what we want to go for is really the optimum.

Mr Hope: Yes, I know.

Ms Grossman: That is what we would like to go for.

Mr Martin: I have come in contact with some of the work you do through some work I did with teenagers and drug abuse and coming from a dysfunctional family and was actually quite impressed. I am impressed this morning by your reiteration of the qualifications, the preparation that you go through, and particularly the 80 hours of personal psychotherapy. You are very together people.

The bottom line for this legislation to me seems to be the protection of the public. You might elaborate on maybe how this particular therapy would be in any way threatening to the public.

Ms Grossman: Art therapy?

Mr Martin: Yes.

Ms Grossman: In the hands of a trained professional, it would not be of harm to the public.

Mr Martin: But there is potential?

Ms Grossman: Just as in anybody's hands, it is important that it is a trained art therapist who is administering art therapy. If it is in the hands of a trained art therapist, then the public cannot be harmed, as far as I am concerned, because safeguards have been built in. We have checks and balances in terms of our own work.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today.

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ONTARIO SOCIETY OF CLINICAL CHEMISTS

The Chair: Next is the Ontario Society of Clinical Chemists. You have 20 minutes for your presentation and we ask if you would leave a few minutes at the end for questions. Please begin your presentation now.

Dr Lustig: Yes, we will. We represent the Ontario Society of Clinical Chemists, four of us—Dr Luxton, Dr Ambus, myself, Viliam Lustig, and Dr Graham Ellis—and we will have two presenters. The first presenter will be Dr Ambus, who will illuminate the committee on what the clinical biochemist does in his daily work.

Dr Ambus: Thank you for the opportunity to give you a glimpse about clinical biochemistry.

First, I would like to tell you how one becomes a clinical biochemist. It takes about 12 years of education after high school to become a qualified clinical biochemist, in the following order. First you get a bachelor's degree, then a PhD in a basic science, such as biochemistry or physiology, or you might obtain an MD. Then you go for a diploma in clinical biochemistry at a university; this takes two years. This is followed by a year's working and passing the fellowship examinations of the Canadian Academy of Clinical Biochemistry so you have the FCACB.

What does a clinical biochemist do? A biochemist may be the appointed laboratory director and report to hospital administration, or the biochemist may report to a director, such as a pathologist or a medical biochemist, and these people are in the regulated health professions. In turn, registered technologists who actually perform the tests report to the clinical biochemist. This group also is in the regulated health professions. So there we are, and we are appealing also to be one of the regulated professions.

The clinical biochemist is responsible for establishing the laboratory standards of practice and directing the clinical laboratory in the areas of biochemistry, special tests, urinalysis, toxicology, and he or she serves as a clinical consultant to the medical staff on matters of clinical biochemistry.

In these times of economic constraints, I feel that the role of the clinical biochemist in choosing the most economically and technically appropriate instrumentation for testing of the specimen and a computerization system for reporting back the results to the physician and personally interfacing with the medical staff and the rest of the hospital just cannot be overemphasized.

I have given some examples of typical situations a clinical biochemist meets on a daily basis.

In the first example, a patient in emergency is suspected to have a heart attack. The physician orders some lab tests and telephones the clinical biochemist for an interpretation of the test results before confirming the diagnosis.

In another example, a physician has received a lab report from biochemistry and is not sure how to interpret the results. In this case, it is an elevated blood level of an enzyme called alkaline phosphatase, and the questions are: Is this abnormal for an adolescent patient; could it indicate cancer; could it indicate liver disease?

In another example, a physician suspects that his patient has taken an overdose of acetaminophen, or Tylenol. The blood drug level is taken and the physician then calls to ask how to interpret the results from the laboratory in relation to the suspected time of poisoning in the patient.

In another example, a physician is concerned about detecting diabetes in a pregnant patient and calls to ask at how many weeks into the pregnancy the special glucose challenge test should be done and how to interpret that.

In another case, a physician has ordered a lipoprotein electrophoresis test. This is an expensive test that is usually sent to another lab, on a patient suspected to have high blood cholesterol. In this case, the clinical biochemist communicates to the physician that several simpler lab tests can be done in-house in a more cost-effective way and suggests the change.

Finally, a serum protein electrophoresis test has revealed that a patient may have a form of cancer. The clinical biochemist orders a follow-up immunoelectrophoresis test to rule out or to confirm the presence of the disease.

These are a few glimpses, and Dr Lustig will continue the presentation.

Dr Lustig: I wish to thank the committee for the opportunity to express the views of the Ontario Society of Clinical Chemists on Bill 43; As a prelude to my remarks, I wish to assure you that the OSCC is supportive of the

intent and spirit of this legislation, namely, to protect the public from harm.

By way of introduction for members of the committee, the OSCC, short for the Ontario Society of Clinical Chemists, represents the interests of clinical biochemists in Ontario, most of whom hold either a PhD or an MD degree or, in some cases, both. In the clinical setting, one of our major roles is to interpret a variety of laboratory results and convey this information and our recommendations to the physician, who relies on our input in deciding the course of treatment. We are one of the health professions that applied to be regulated under the Health Professions Legislation Review and were not accepted, although we believe we came very close to being included at the first round. We therefore have maintained an ongoing and positive dialogue with the Ministry of Health, which we intend to continue in the future.

It is our understanding that Bill 43 is still subject to amendment at this stage in the legislative process, and therefore today's presentation will focus on two aspects. First, we would like to ask the committee to amend bill 43 so as to include the OSCC in the family of the regulated professions to facilitate our working effectively in concert with the other health professions. Second, we wish to express our concern regarding section 30, dealing with the restriction of the use of the title "doctor."

With regard to the first point, the reasons that prompt us to seek self-regulation are based on the sincere desire of our membership to protect the public from unqualified practitioners. In our role of clinical biochemists, we believe that we present a potential risk to the public through five of our important functions summarized below:

1. Clinical biochemists establish normal values for tests, against which all patient results are interpreted.
2. Through the interpretation of test results, clinical biochemists advise physicians about treatment decisions which could well pose a risk to the patient.
3. Clinical biochemists serve on utilization committees which determine which of the tests should or should not be ordered for specific categories of patients.
4. Clinical biochemists are directly responsible for quality assurance in the clinical biochemistry laboratory.
5. Clinical biochemists take an active role in the laboratory proficiency testing program, LPTP, of the Ontario Medical Association. LPTP strongly influences the standards of practice of laboratory medicine throughout the province of Ontario.

The omission of the clinical biochemists from Bill 43 poses other potential serious risks to the public in that anyone could call herself or himself a clinical biochemist and practice without being qualified. This would lead to (a) clinical biochemistry tests being interpreted improperly; (b) physicians receiving unsuitable advice upon which to make patient care decisions, and (c) inappropriate utilization of scarce health care resources.

Furthermore, there is a clear inconsistency in Bill 43 in that the technologists who perform the clinical biochemistry tests and the physicians who rely on our interpretation of the results of these tests for patient care are included, while we, the clinical biochemists, who obviously are an

integral part of the continuum of health care provided by laboratory medicine, are not included.

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A severe shortage of clinical biochemists is anticipated in the next decade. Even with the Ministry of Health's financial support for post-doctoral students in clinical chemistry, the non-regulation of the profession may deter some promising candidates from becoming clinical biochemists. This would deprive the public of the high standard of clinical biochemistry services which it deserves.

Our second concern with Bill 43 is focused upon section 30 and its restriction on the use of the title "doctor." As clinical biochemists, we interpret a wide variety of laboratory results. Our interpretations are often relied on by physicians in making patient care decisions. These interpretations are an integral component of the health care continuum. Therefore, we as clinical biochemists fall within the scope of "providing or offering to provide, in Ontario, health care to individuals" as stated in section 30. It follows that we could then be subject to the restrictions in the use of the title "doctor" as currently drafted in section 30.

Under clause 39(1)(d) of Bill 43, the minister may make regulations allowing the use of the title "doctor." Therefore, the OSCC strongly urges the committee to exempt by statute or regulation OSCC members who hold a PhD degree from a recognized university from any restriction regarding the use of the title "doctor."

In summary, the OSCC asks that Bill 43 and any regulations thereunder be amended such that (1) the profession of clinical biochemistry should be included in the regulated professions; (2) clinical biochemists should be permitted to continue to use the title "doctor."

Should your committee, for whatever reasons, be unable to include us at this time, we will seek inclusion by making the necessary submissions to the Health Professions Regulatory Advisory Council as expeditiously as possible.

Mr J. Wilson: Thank you for your presentation. It was very informative. On the question of the use of the title "doctor," I have a great deal of sympathy for PhDs and would like them to continue using the term, although under the current Health Disciplines Act there really is a prohibition against using the term now. In the hospital setting, are you commonly referred to by your colleagues on the medical staff as Dr Such-and-such?

Dr Lustig: Yes, without fail.

Mr J. Wilson: Second, on the regulations, actually this committee will not see the regulations. They are established by the advisory council, the minister and will be adopted by cabinet, so we will have to clear up the area of title protection in this particular bill.

Ms Haack: Following up on what Mr Wilson has presented, how much patient contact do you actually have?

Dr Lustig: Generally speaking, not very much patient contact. It is mainly physician contact. Physicians are our prime customers, if you wish.

Ms Haack: Obviously, in the eight years this piece of legislation has been part of the long-standing agenda of the various governments, the case has been made that the patient

or the consumer of health care services can be confused by the use of the word "doctor" by the wide variety of specialties he may come in contact with. In reality, as far as the academic designation is concerned, I believe it is also the feeling of the Ministry of Health that you are not prevented from calling yourselves PhDs or some sort of designation in that way.

Dr Lustig: That is fine. All we want is to be specifically included under clause 39(1)(d). That is what we in essence are saying.

Ms Haeck: But you are not really excluded here. As part of your academic qualifications you have PhD attached to—

Dr Lustig: It is certainly a grey zone. We would like to have a clearer image. Therefore, we continue to ask to be specifically included those with a PhD from a recognized university, so of course that does not apply to MD colleagues who are entitled to do so.

Ms Haeck: I would like to ask one more question, if I may, which relates to Dr Ambus's wonderful list of the academic qualifications you do have. Does that form the normal job description, the criteria under which you would each be selected for your job?

Dr Ambus: If you are a fellow in the Canadian Academy of Clinical Biochemistry, yes, these are your qualifications.

Dr Lustig: If I may comment, 98% at least have these qualifications and maybe some older people, two, three or four, who have been grandfathered have their MSc, but this no longer occurs now. You must have a PhD.

Mr Beer: If I could pose a question to the parliamentary assistant, in the organizations that are being self-regulated, we include the radiation technologists and the medical laboratory technologists. I am wondering in the reasoning of the review why it was found this organization should not be self-regulated. I do not claim to understand exactly how all of these groups work, but there does seem to be a certain commonality around doing tests and investigations in a clinical or laboratory setting. I wondered if we could ask to have that clarified.

Mr Wessenger: I will have counsel reply to that question.

Ms Bohnen: The primary reason the review had for not recommending this profession for self-regulation was its numbers. It is a very small group, certainly relative to the number of medical laboratory technologists. As they have pointed out, many of their members also have MDs, and if they are licensed by the College of Physicians and Surgeons, they are regulated in that way.

Dr Lustig: May I just comment on these remarks?

The Chair: Mr Beer has a question.

Mr Beer: My question will allow you to comment. In light of that, could you underline why you believe, as an organization, you need a specific regulatory body instead of falling essentially under the College of Physicians and Surgeons?

Dr Lustig: First, I would say that no more than 10% of our members are medically qualified practitioners. Sec-

ond, I do not think the numbers are particularly relevant. One ought to be regulated to protect the public, not because one is a big group or a very big group. I think we present a significant risk to the public. We make major decisions and we are listened to by our clinical colleagues.

Mr Beer: Just for the record, roughly how many members do you have in your association?

Dr Lustig: Right now, 183 in Ontario, roughly 500 in Canada.

Mr Martin: From some tours I have had of various medical centres, it seems to be that a lot of computers are used now to do certain work in this area. You could respond to how that impacts on what you do and how that also perhaps produces a risk to the public.

Dr Lustig: We are the people who choose a computer system. We are intimately involved with the system. Of course, computers will make health care more efficient, but they are just machines that need to be guided. Again, it is a clinical biochemist who very often sets the standards as to what these computers should be doing.

The Chair: Thank you for your presentation. We appreciate your coming before the committee today.

1140

COLLEGE OF DOCTORAL SCIENTISTS IN LABORATORY MEDICINE OF ONTARIO

The Chair: Next is the College of Doctoral Scientists in Laboratory Medicine of Ontario.

Dr Groves: I am Dr David Groves. I am a microbiologist at St Joseph's Hospital in Hamilton and I will make the presentation. Dr Max Chernesky, a virologist, and Dr Jim Mahony, also a virologist at the same institution, are here as resources for me. We are appearing before you on behalf of an organization which represents the Doctoral Scientists in Laboratory Medicine of Ontario. It is a little bit of a long name but it covers quite a broad area. We would like to increase your awareness of the vital and significant role these individuals play in health care in Ontario, that their regulation may be formalized under the Regulated Health Professions Act with which we are concerned today.

This is an extension of the previous excellent presentation by the clinical chemists, and I will explain that as I go along—an extension in concept, not of their presentation.

Every hospital in Ontario of any significant size has a laboratory to assist in the diagnosis and management of disease, and in many cases doctoral scientists are heavily involved in the performance of these laboratories. They often set policies for the processing of specimens, interpretation of results, and maintenance of quality assurance, with emphasis on the word "policies." They are especially equipped to apply new and more basic scientific technology to the analysis of patients' specimens.

Doctoral scientists hold PhDs or DSc degrees, usually achieved by working in medically oriented problems, and have had additional training in clinical diagnosis. In my case, I have a PhD from the University of British Columbia in basic bacteriology and molecular biology. During my post-doctoral training in the University of Rochester in

Rochester, New York, I took a training course that converted me into a clinical microbiologist capable of directing a laboratory in the United States. I have subsequently, by examination, received a diplomate of the American Board of Medical Microbiology and I am a specialist in clinical microbiology as certified by the Canadian College of Microbiologists, which is an equivalent certifying organization.

In Hamilton, as in other centres in Ontario, about one third, and in fact in several disciplines up to one half, of the laboratory professionals are laboratory scientists. The specialty areas include, but are not limited to, clinical chemistry, microbiology, haematology, genetics, pathology, and immunology. Several of these groups have established self-regulation mechanisms which endeavour to ensure, on a voluntary basis, that the public good is not compromised by a lowering of standards, either in training or in practice. The voluntary accreditation of training programs and voluntary certification programs are in place nationally due to the efforts of the Canadian Academy of Clinical Chemists and the Canadian College of Microbiologists, and other groups are partially self-regulated or in the process of developing such regulation mechanisms. Maintenance of certification through continuing education is a major requirement for the certifying agencies. In my case, I have to submit for recertification a record of my continuing education every three years to the American board and every five years to the Canadian College of Microbiologists.

In spite of these voluntary efforts, and because of the multiple disciplines involved, there still is significant potential for delivery of substandard care to the patients through either inappropriate training or certification or getting the wrong person in the right job. There are over 300 doctoral scientists in hospital public health and private laboratories in Ontario who are responsible for the processing of clinical specimens. In a survey of these individuals across all disciplines, over 150 responded, all favourably, to the concept of forming a multidisciplinary college of clinical and laboratory scientists in Ontario. Incorporation of such a college has been initiated and the structure of the college is as outlined in our brief. It is specifically designed to conform to the outline of structures of colleges in the initial draft legislation.

This organization is intended to initiate specific self-regulation for Ontario on a voluntary basis if necessary. Inclusion of this college in Bill 43 will formalize and strengthen this mechanism of self-regulation. Our objective in making this presentation to your committee is to have doctoral scientists in lab medicine included under the Regulated Health Professions Act through an amendment and to obtain a separate amendment relating to our profession. This will formalize the self-regulation of our profession in Ontario, thereby ensuring the safety of the public.

Mr Beer: Your presentation and the one just before it—it seems that every day we find there is yet a new area that, as laypeople, we are not necessarily as aware of as perhaps we ought to be. We noted that there are people who are working in laboratories who are being registered doing different kinds of things. This may be an absurd question, but is there some sense that you yourselves, the

clinical chemists, perhaps some others—if it appears part of the problem is around, or was seen to be around, numbers but not necessarily around function, is there some point in looking at bringing together people who are engaged in a clinical setting with a number of different backgrounds and approaching the problem that way? I am thinking specifically of what you do and what the presenters before you did.

Dr Groves: In actual fact, this presentation is intended to include the clinical chemists, clinical haematologists and other disciplines. We happen to be microbiologists.

Mr Beer: So in fact what you are looking at here really is covering all of those who are working within some kind of laboratory clinical setting.

Dr Groves: Those people who hold a PhD or a DSc, who have clinically specific training and who are working in the clinical environment, a laboratory.

Dr Chernesky: If I could just follow up on that, our initial discussions began two years ago to formulate this college and our discussions included all six disciplines Dr Groves has talked about in Hamilton and subsequently Toronto. We have spoken with our colleagues from London through to Kingston. The idea of this is to form a college of all doctoral scientists covering all disciplines, including the clinical chemists, and we think that is a rational approach.

Mr. J. Wilson: Had you appeared before the legislative review committee? It sounds like you are well on your way to meeting the requirements. About how far along in the process are you in meeting all the requirements of the legislative review committee?

Dr Groves: We have not appeared before them. I am afraid I do not know.

Mr J. Wilson: When I read the table of contents on your charter, it seems to conform very well with the legislation.

Dr Groves: We specifically designed it. We took the original document and we specifically adapted it for this purpose. We would like very much to make it as easy as possible to meet those requirements and get in this time around, as opposed to in a later process.

Mr J. Wilson: It is a decision the minister herself would have to take and bring before this committee, the government itself would have to take, but there is the advisory council which would give you another kick at the can once it gets going, I think, the way I understand the process.

Dr Mahony: Thank you very much. One of the reasons we have not been in at a previous time is because that is a relatively new concept. We really only started a couple of years ago, but I think all of the representatives of the disciplines in Hamilton, where it all started, feel quite strongly that the major objective is to form a college. Whether it gets included in the legislation or not is another matter, but we do feel quite strongly that the college will regulate. We can self-regulate ourselves to the point that we can be responsible enough to make sure the public is protected, because these people are doing major things

within laboratories, have patient contact and make fairly important recommendations along the way. I think this group of people really needs to be regulated one way or another.

Mr Frankford: Have you given any thought to your relationship with medical lab technologists, and could you see any model or way you could include them as well?

Dr Groves: The roles of the technologist and of the doctoral scientist really are significantly different. The doctoral scientists are working at the level of interaction with colleagues. For instance, I am on the special professional staff of the hospital where I work, which is a subsection of the medical staff of the hospital. We are involved in direct discussions about management of patients. We are involved in deciding what proportion of the reports will actually get into the patients' charts. We make policy decisions concerning the management of information that comes from the laboratory. The technologists, to a large extent, carry out those policy decisions. That is a big difference in role.

In actual fact, the technologists are such a large organization and have such specific activities and specific interests that the regulation of doctoral scientists would probably be swamped in the larger body. I believe the technologists were not very interested in having us have anything to do with them when they were originally generating their proposal. There are a number of reasons, historical or whatever, that it probably would not fly.

Ms Haeck: I was going to ask how much patient contact you really do have. I would assume, and obviously you are in a position of correcting me, that you do not perform the actual pricking of my finger to do a blood test or some of these other things; it is someone else who would be doing that.

Dr Mahony: I would probably be the best person to respond to that because I am the director of a laboratory. As far as patient contact is concerned, I probably see three or four patients a week in my office. These are specifically recommended to me because of my specialty as a virologist and my experience in being able to assess a clinical situation, look at a rash and try to make a recommendation as to the type of tests and specimens that ought to be taken. There is that arm of the patient contact.

Most of my time, however, is used up in consulting with physicians as to what they ought to be doing with their patients as far as management of the patients is concerned and as far as specimen collection and diagnosis are concerned. Virology specifically is such a rapidly moving field that most physicians have a very difficult time keeping up with that particular cutting edge of microbiology, and so it takes a specialist like me, who can spend the time, to keep them abreast.

Ms Haeck: Are you doing some research as well?

Dr Mahony: Yes, we have an active research component. We are particularly interested in my laboratory in the rapid diagnosis of infectious diseases, so we are actively pursuing that type of activity. Because of my previous training, I am able to take those basic concepts in microbiology and apply them to the patient as far as diagnosis is concerned.

Ms Haeck: You all have the same basic educational standards as well.

Dr Mahony: Yes.

Ms Haeck: It runs consistently through, even with the previous presenters, that really, in order to fulfil your job function, you have to meet certain academic standards.

Dr Groves: Just one quick additional comment on that: Another area that we are discussing as far as its speciality is concerned is genetics. There are a number of PhD-level or DSc-level people who are working in genetics diagnostic labs who are also involved in direct patient contact and counselling of patients as a result of the laboratory results, and so they do have patient contact as a major component of their particular activity.

The Chair: Thank you very much for your presentation. The committee appreciates hearing from you today. As I said before, if there is any additional information that you think would be helpful to the committee members during the course of these hearings, please feel free to communicate in writing via the clerk.

The committee stands adjourned until 2 o'clock this afternoon.

The committee recessed at 1155.

AFTERNOON SITTING

The committee resumed at 1401.

The Chair: I have a request from the parliamentary assistant to add something on the record.

Mr Wessenger: Yes, I would like to have staff make a comment with respect to ambulance attendants.

Ms Bohnen: I would like to give you one more piece of information about the review's reasons for not recommending that ambulance attendants be a self-regulating profession, which is that the review was aware that the Ministry of Health was planning to conduct a review of ambulance services. In fact, there is currently a review going on of not just ambulance but emergency health services which is intended to be completed in 1991. The review felt that kind of review would address the issues being raised by the ambulance attendants.

Mr Hope: So there is always a possibility they may be self-regulated, depending on the outcome of the review.

Ms Bohnen: I think the review was mindful of the fact that there are different mechanisms whereby issues raised by the occupational group can be addressed. One of them is self-regulation under this framework. Another is often a different kind of regulation under a specific statute, such as the Ambulance Act, for these people. The review knew they had issues, but felt they were best addressed within the framework of the review of emergency services and ambulance services, rather than making the determination at that point that they should be a self-regulating profession. Certainly the ministry has no idea what is going to come out of the current review of emergency services, but in any event the advisory council will be there for the ambulance attendants' association to make its application in the future.

MISSION SERVICES OF HAMILTON INC

The Chair: I now call Mission Services of Hamilton. You have 20 minutes for your presentation, and if you would leave a few minutes at the end of your presentation for questions from committee members, we would appreciate that.

Mr Buckley: My name is Mike Buckley. I am the director of the Marty Karl Centre for Personal Development, which is one of the four service divisions of Mission Services of Hamilton Inc. With me is Kelvin Honsinger, our newly appointed executive director.

Mission Services of Hamilton Inc, and we as the mission's representatives, would like to thank the standing committee on social development for this opportunity to speak today regarding the effect that Bill 43, the Regulated Health Professions Act, would have on our various services if it were passed into law in its present form.

Mission Services of Hamilton is a non-denominational, evangelical Christian mission that has been active in Hamilton for over 35 years. We currently operate four front-line service divisions: Inasmuch Home for Women in Crisis, Ontario's largest and longest-running shelter for abused women; the Men's Residence and Rehabilitation Centre, a

men's hostel providing crisis care and drug and alcohol rehabilitation; our Family Help Centre, which operates several stores providing used clothing, furniture and appliances at affordable prices or as a free gift to those with a demonstrated need, a crisis food bank and a Christmas hamper program; and the Marty Karl Centre for Personal Development, which provides vocational assessments, training, case management and a supported employment program for adults with various physical, intellectual and psychiatric disabilities.

Three of these four programs' services are mandated by existing agreements with the region of Hamilton-Wentworth and the Ontario Ministry of Community and Social Services to provide assessment and counselling services. In the course of providing these services, we routinely deal with the disease of alcoholism and the effects of physical, mental and sexual abuse which include, among others, eating disorders and sexual dysfunctions. When dealing with disabled adults, we provide our assessment conclusions regarding a given person's functioning—or dysfunctional aspects—in writing.

These examples name only a few instances out of many possible ways in which we communicate to the individuals in our care a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual will rely on the conclusion. We therefore have been justifiably concerned that paragraph 26(2)1 of Bill 43, the so-called "diagnosis" clause, would create a situation where the activities of our staff, functioning within the limits of their professional training, would be considered unlawful. This, according to section 36, would cause them, their supervisors and our volunteer board members to be open to charges carrying a penalty of up to six months in jail and/or a fine of up to \$25,000 in each instance.

We have not been convinced by statements made by the members of this and the previous government that we are unlikely to face these risks. Although the chairperson of this committee, Elinor Caplan, in her previous role as Minister of Health stated that it was not the intent of this legislation to attack social workers, pastors and counsellors, among others, who were functioning within the level of their professional training, we are well aware that once legislation is passed into law it is the courts who interpret the law and the officers of various police forces who are charged with the duty of enforcing the law.

It would be irresponsible of this Legislative Assembly to pass any bill that has ambiguous terminology or that relies on an unstated and unwritten "intent" to guide those who must work out the practical aspects of applying legislation to cases. Therefore, if the terminology of this bill is permissive and would allow for an unintended application whereby Mission Services of Hamilton, similar agencies and unregulated professionals might face prosecution, the wording should be changed to protect innocent parties from the unintended effects.

We are aware that the current Minister of Health, Frances Lankin, has said to the Legislature that she is not convinced the diagnosis clause would cause problems for the unregulated practitioner. Therefore, we have sought legal opinion to clear up any uncertainty she, this committee or the Legislative Assembly charged with the duty of passing this legislation may have.

In a legal opinion given to Mission Services of Hamilton by George Gresko of the firm Milligan, Gresko, Charuk and Rogers, we have had our worst fears confirmed. It reads in part, "The work presently carried on by the personnel at the mission appears...to fall directly within the scope of section 26(2)1 of the act and accordingly, the present 'counselling' function carried on at the mission would, in all likelihood be rendered unlawful."

There are in Ontario uncounted numbers of crisis centres, hostels, shelters and other mental health services and programs that rely heavily on the services of professional counsellors and staff who are not eligible to become members of a college of a designated health profession within the meaning of this bill, nor able to be supervised by a member who could delegate such authority, and who are providing counselling and assessment services which this legislation would undoubtedly throw into a similar lot with Mission Services of Hamilton. We would therefore urge this committee to take a closer look at this bill.

1410

If it could be shown that this legislation itself is in contravention of its own stated purpose, would this committee be prepared to make changes to this bill? According to section 3 of Bill 43, it is the duty of the Minister of Health and the purpose of this legislation "to ensure that the health professions are regulated and co-ordinated in the public interest...and that individuals have access to services provided by the health professions of their choice." We believe we can show that the diagnosis clause, paragraph 26(2)1, would not provide for regulating and co-ordinating the health professions in the public interest and that the end result of this legislation would be to decrease the access individuals have to the health professions of their choice.

We first raise the question of whether "diagnosis" as an activity, however described, is rightly the sole domain of the medical profession. It would appear not, in that social workers and licensed professional counsellors in many jurisdictions in the United States have been granted the right not only to diagnose, but to do third-party billing to insurance companies based on their diagnoses. For that purpose, they use the Diagnostic and Statistical Manual of mental disorders, referred to in its current edition as the DSM-III-R.

It is interesting to note that the DSM came into existence as a companion to the International Classification of Diseases, which is the medical doctor's standard for diagnosis, so that mental health professionals who did not have medical training would be able to provide diagnostic services. It therefore seems ludicrous, with such an extensive diagnostic tool as the DSM-III-R intended for non-medical use, and the clear precedent set elsewhere, to attempt to claim that diagnosis as a whole is only and solely the privilege of the health professions.

Second, if, as seems apparent from the legal opinion we have obtained, social workers, psychotherapists, counsellors and other mental health professionals are to be forced to run the risk of legal prosecution or cease to provide their services which necessarily entail "diagnosis" as described under the act, there are two likely results. Either these services would have to be provided by medical doctors, psychiatrists and psychologists or the individuals under their supervision, or eventually these and other professions would have to be licensed under this or other legislation to carry out these much-needed activities.

In the first case, Ontario is already having a difficult time with the ever-increasing costs incurred through the Ontario health insurance plan, OHIP. With the increased duties for these high-priced medical professionals, it is clear we can look forward to increased costs. Currently there are many more unregulated mental health practitioners than there are psychologists and psychiatrists. Therefore, there would also necessarily be reduced access to mental health services.

In the second case, there is some doubt whether this legislation even allows for an exemption for professionals licensed under separate legislation. Section 28 of Bill 43, which contains the exceptions under which persons could seek relief from the regulations in the act, does not mention the case of a different act providing for the licensure of professionals who are currently unregulated and who might wish to organize and seek licensure so as to carry on their professional duties, which in part, and certainly in the case of "diagnosis" as currently defined in section 26, would parallel proscribed acts under Bill 43.

Under clause 39(1)(b), the minister can create an exception at a later date, but if the intent is to allow other regulated professions to practise in the future, why not state so explicitly now? The current situation could be misunderstood by suspicious persons as putting up as many barriers as possible to currently unregulated professions becoming regulated at a later point in time, so as to preserve a lucrative monopoly in third-party billing for counselling and assessment services for the medical profession as long as possible—possibly for ever?

As a case in point, the Ministry of Community of Social Services, in its consultation paper entitled Regulation of Social Workers and other Social Service Practitioners, has responded to the request of the Ontario Association of Professional Social Workers and the Ontario College of Certified Social Workers to consider legislation regarding the regulation of social workers and other social service practitioners in part because "the Health Professions Legislation Review found merit in the association's proposal [but] determined...that if professional social workers were to be regulated it would be more appropriate that such legislation made them accountable to the Minister of Community and Social Services."

Therefore, it is clear to see that steps have already been taken by at least one body to be recognized as a regulated profession outside of this act. Why not recognize this all too likely possibility now with the appropriate wording?

However, returning to our argument that the diagnosis clause does not fulfil the intent of the act in that it does not

provide for the co-ordination of health services in the public interest and that it decreases access and public choice in professional services, in the case where this committee was able to make changes to this legislation so that either other acts would be expressly permitted exception to the Regulated Health Professions Act, or they were expressly permitted to organize under the act, we would submit that this would naturally entail an increased cost to employ such licensed individuals which is either passed on to the public directly or indirectly through the increased cost of insurance, whether it be private insurance or OHIP, or as in the case of transfer of payment agencies under the Ministry of Community and Social Services, increased taxes and/or reduced services to cope with the increased costs.

It is important to note that while this might increase the credentials of the individuals in a given field, there is no guarantee that it would in any way improve the services, but it most certainly would push up the costs and decrease the accessibility and the element of choice of such services to the public.

It is the responsibility of government to pass legislation that fulfils its intent and at the same time does no unintended harm. We feel we have shown that this legislation, in so far as the diagnosis clause, paragraph 26(2)1, is concerned, fulfils neither of these prerequisites. We have a legal opinion that states that our everyday activities in three quarters of our programs would be unlawful under this bill. We have demonstrated that many other social service programs, including drug and alcohol rehabilitation programs, shelters and hostels, would all tend to be at risk of the same fate. The end result of passing this legislation in its current form would be to bankrupt many social service programs, increase costs and decrease public choice and accessibility.

It would therefore be unconscionable for this committee to return this bill to the Legislative Assembly without changes to paragraph 26(2)1 that would clearly protect the medical profession's right to medical opinion without at the same time taking away many other legitimate mental health professionals' right to express an opinion within the limits of their training and experience. If suitable wording is not forthcoming, it would be better to strike the clause from the bill, and in so doing fulfil the intent of the legislation, which is to ensure choice and access by the public.

As a final point, we would like to say that we have come to this venue today in good faith that this committee is indeed unbiased and willing to make changes to this bill to make it both fair and reasonable. We urge this committee to make changes in this bill to preserve the rights of unregulated practitioners to work within the limits of their training and experience, including the communication of opinions and diagnoses, so that the public really does get freedom of choice, of access and a responsibly co-ordinated health system organized in the public interest. We will be watching these proceedings with great interest.

1420

Mr J. Wilson: Thank you for the excellent presentation. I think you have made one of the most compelling arguments. Although we have heard from a number of

other groups concerning the diagnosis clause, you have made one of the best and most succinct arguments that we have heard to date. I think it is the intent of this committee, and certainly the will of this committee, to try and make changes to the bill so that unregulated practitioners will be more comfortable.

I note in your legal opinion that there is not a suggestion of any new wording we might put into the act. I am just wondering if you gave any thought yourselves to that, other than I see you also make the suggestion we should simply strike the clause. We are grappling as a committee, trying to come up with wording. There is the exemption section, section 28, that I think tried to give some relief in the area of your concerns, but given the current act, perhaps you would comment on what you might exactly do with it, other than strike the clause, which might not be a good option.

Mr Buckley: I do think that striking the clause would be a very good option in that it leaves the whole area then open. I think the consumer still has quite a bit of protection in other areas of law about mismanagement and misrepresentation by individuals.

Mr J. Wilson: Some have suggested in the area of protection that perhaps all that is needed is title protection.

Mr Buckley: I would agree with that. If that is not acceptable, probably the next best option might be the inclusion of something in terms like "medical diagnoses" or something. Although not expressly, that would tend to limit that to, for instance, items that are included within the International Classification of Diseases, and probably, I would think, leave the DSM-III-R and similar types of volumes to their original intent, or at least it could be argued in court that somebody made a diagnosis under a different body of publicly recognized information, rather than necessarily going into the medical area. At least there is a defence there, whereas currently there is not.

Mr Beer: Thank you for your presentation. At the bottom of page 9 where you say "and in so doing fulfil the intent of the legislation, which is to ensure choice and access by the public," I think we also would have to add to that "and protection."

I recognize there is a balance here, but personally I do not think we can simply drop the clause. We see, through presentations that have been made, that there are real concerns around how that might affect people, but from outside, looking at how we achieve that balance, we have to look at the intent of the legislation as being twofold.

The Coalition of Unregulated Practitioners gave us a number of proposals to look at changing the wording and how we might approach that. Have you had an opportunity to look at any of their proposals? I think we have to find something that is going to help achieve that balance, and I suspect we would find that simply dropping it could open up the possibility of risk to the public, not from you but from others. I am just wondering if you have had a chance to look at that other wording, and if you have, chance to look at that other wording, and if you have, if you could elaborate on that.

Mr Buckley: I did get a chance to look at that document. Unfortunately I did not go into it at length. I did not find any of the options particularly exciting.

Speaking to your question about balance, yes, there definitely is a need for balance. At the same time, I think we need to recognize that the medical perspective is one perspective of many. As a rehabilitationist, my perspective is the rehabilitation philosophy, which is a non-medical philosophy. In dealing with individuals, we find ourselves at times at odds with medical professionals and we need to respect each other's positions. Right now the balance of power and the balance of protection seems to be wholly on the medical side, so I am not as concerned about protecting the medical profession's turf at this point, because at this point they do not seem to have that much need of protection.

Mr Beer: From the committee's perspective, I do not think that is our specific interest either. I think, though, that in trying to reflect some sense of public good, there is an interest to protect the public from those who, whether medical or non-medical, would seek to provide some sort of diagnosis for which they had absolutely no training and no responsibility. It is just that I think we have to be conscious that this is the dilemma we face as a committee in finding the balance that, frankly, will allow you to do what you have been doing, but do both of these things.

Mr Buckley: We are a certifying society. Long term, we are probably looking at a whole host of social service professions that are certified and have some legislation allowing them a certain rein. From my perspective, that is a bit unfortunate, but it is probably the direction we are going. If you look in the United States, you will find there has been an awful lot of work done. I was recently down in the United States over the summer and was able to talk to people about the state down there of the different bodies of legislation. It is quite confusing, but that seems to be the direction they are going as well. Again, I would say it is unfortunate.

SOUTH GEORGIAN BAY MINISTERIAL TASK FORCE ON BILL 43

The Chair: I would like to call now on the South Georgian Bay Ministerial Task Force on Bill 43.

Mr Gehrels: My name is Ken Gehrels and beside me is Ken Barker. If you just refer the questions to Ken, we will make sure they are properly taken care of. "Hey you" or a suitable grunt in either direction, and we will make sure we get across.

Thank you for giving us the opportunity of presenting to you. I do not envy your job. I do not have to sit in that kind of chair except but three days a year, and those are the three lousiest days of my life. So hats off to you folks for the work you are doing.

I will just run you quickly through the presentation you have before you. Who are we? Basically, a task force that represents the ministerial associations, and hence the churches, pastors and parishioners, who run all the way from the Wiarton area, around the south edge of Georgian Bay, right up again to Penetanguishene, Midland, Victoria Harbour and all the communities in between.

Our concern, which I understand has been a concern raised by many other folks already to you people—I certainly hope we are not beating a dead horse, to use the old phrase—is that part of our mandate is to provide pastoral care and support to our parishioners, so we, as many others, have an interest in Bill 43.

From our understanding of the bill, having read it, we are appreciative of your desire to revamp the health care regulatory process. We support the basic intent of it. However, as with others, our concern is paragraph 26(2)1, the concern that the diagnosis clause could lessen the quality of pastoral care provided to the parishioners whom we are representing to you here today and inhibit the positive contribution that presently is made by clergymen and clergywomen on a grass-roots level all across the province to the quality of life in this province.

It is with those words "disease," "dysfunction" and "disorder," and the concern is whether you intend in the legislation to retain a narrow medical definition of the words or whether it allows a broader understanding. I think it is safe to say from the intent of the legislation, if one looks at it overall, that we are probably looking at the narrow medical model or definition of the words. Of course, both are technically possible. The legislation does not really say which one is intended.

It is our hope, and we were glad to hear what you mentioned to the group prior, that you are seeking to work as a proactive rather than a reactive sort of committee so that work does get done in a positive sense to prevent, somewhere down the road, a possible hindering of the work that clergymen and clergywomen carry on all over this province in—I give some examples—things like alcoholism that families who are struggling with wife assault.

That is a particular interest of mine at the moment. I also sit on the board of the Collingwood women's emergency shelter which we just celebrated the opening of, My Friend's House. I bring here personally not only my own concerns as a clergyperson, but also the concerns of the staff whom we have hired on at My Friend's House. What is their status going to be if the legislation were to be passed as presently implemented here?

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Struggles with victims of incest; brokenness surrounding divorce; grief counselling—how many people do not avail themselves of clergy if at no other point than there?—pre-marital counselling. We do all that sort of work on a regular basis and the question becomes then, are we going to be able to carry on that sort of work which often does involve, in a broad sense, diagnosis- and directive-oriented counselling?

I think of one individual I counselled who had been convicted of and openly admitted to an incestuous relationship with a child. I had to work arm in arm, together with a social worker in the community of similar persuasion to mine, to help this person understand the particular implications of his acts and the damage it caused to the child. We worked on that and some time later this person came down with a very strange disease whereby his hands were rendered numb and tingly and he could not use them. He came down with this complete conviction that he was

suffering under a punishment and the guilt of God for his activity. The guilt he was feeling was so tremendously crippling to the man that he just simply could not carry on with life. He was unable to proceed with medically healing his disease, so we had to deal with the diagnosis then, in a guilt sense, of what he was struggling with and help him overcome that.

That is one example. There are others. One person I was on the telephone with this morning, before I came down here, had been betrayed by a member of her family, had been hurt deeply, was losing weight and could not sleep and the symptoms went on. Over time we were able to diagnose the cause of these symptoms she is experiencing as her resentment, her rage, properly so, against that particular individual and then help her directly to work that through, just to give you a couple of concrete examples of where we are coming from in our profession.

We understand that you are seeking to regulate, not to box in. We appreciate that. It is with that in mind that we would like to present to you four different suggestions, on page 2, as to what possibly might be helpful, or at least provide an avenue in sorting through the present predicament.

I would like to begin with proposal 2, "Delete 26(2)1 entirely," and just ask the question, perhaps in a rhetorical sort of sense, recognizing what Mr Beer has already mentioned, is the rest of the list, paragraphs 26(2)2 to 26(2)13, not sufficient in terms of the protection it provides to the public? I think here of the way our society in general runs. We are a society that works very much with individual responsibility, individual freedom and freedom of choice, recognizing that it is government which then sets the boundaries of safety so that people do not get unnecessarily damaged or hurt when they make the particular choices they are seeking to make.

Paragraphs 26(2)2 to 26(2)13 speak of all the different poking and prodding and working with various corners and crevices of the body. The question I ask to members of the committee, and perhaps we can discuss this in a couple of minutes, is, does that not provide, in and of itself, sufficient protection for people who honestly are going to look for some kind of assistance for whatever conundrum they find themselves in? If you say no, then up to number one: Would it then perhaps be beneficial to stake down what I would put in quotes as "individual fence posts," perhaps an item-by-item designation of what kinds of diseases, disorders and dysfunctions may or may not be diagnosed by only those in regulated professions? I know it becomes a little more awkward, a little longer.

If we are concerned with working on the narrow meaning, the narrow definition of the words, especially "dysfunction" and "disorder," then perhaps something like number three, communicating a conclusion regarding a medical, dental or optometrical disease, dysfunction or disorder—I do not know exactly how you would want to word that—and then in some way, somehow refer to the body of common law that has already been built up which prevents people from practising medicine without a license. That body of law is there now. Can we not perhaps

make use of that somehow by using the words "medical diagnoses," perhaps? Then when we have this whole body of legislation in place it can be utilized. It seems to be working fine so far. It has not impinged on social workers, parole officers or clergy to date. I cannot see that changing.

Then there is number four. I like that one the best because I wrote that one.

Mr Owens: Sounds good to me.

Mr Gehrels: There you go. No, the basic idea for that one came from Don Evans from the coalition. His concern, as he has probably mentioned to you, is with scope of practice rather than specific item-by-item definition of what may or may not be done. Where are we going to get our hands slapped? Where are we not going to get our hands slapped? That got us in the south Georgian Bay task force thinking, is it perhaps not misrepresentation that is in a large way the concern of you folks in the committee, playing doctor? If I look at clause 26(1)(a), subsection 30(1) or subsections 31(1) and (2), that seems to be the case. It seems to come up over and over again in the bill. That is a concern we share. I do not want to, and as clergy we ought not to want to, engage in detailed medical or psychiatric analysis of our clients. We are not called to that and are not trained for that; wrong bailiwick.

Could we say something like, "Communicating to the individual or his or her personal representative a conclusion regarding a disease, dysfunction or disorder in which it is reasonably foreseeable that the individual or his or her personal representative will understand this conclusion as having been made by an individual authorized by a health professions act to perform treatment regarding this conclusion?"

Then you go to the scope of practice of each of the individual professions as you define them with the various health provision acts that go along with this particular bill. I guess what we are looking for is complete legal assurance that our day-to-day provision of competent pastoral care is not hindered. I have no interest in protecting the quacks, like the guy who receives a vision after a bottle of wine, calls himself a reverend and starts counselling practice. That is not our intent. Competent counselling, pastoral care: We do not want that hindered. We do not want that put under a cloud of possible legal action in any respect. I think the parishioners we represent deserve nothing less and I am sure you would agree on that.

The final thought is that we do not understand how the government could on the one hand call for grass-roots health care—I consider mental health, spiritual health to be part of the overall wellbeing of a person. I think our society is more and more coming to see that. We are not just bodies with little minds stuck in them. We are whole people and with all different aspects to our wellbeing. I agree with the call I hear coming from Queen's Park, time and again, for front-line care, for grass-roots care, for community-owned and cared-for work, preventive care especially. I think that is good. But then we cannot at the same time hinder that by trying to stuff everybody into a narrow medical model. As you know by now, we just simply do not all fit. I thank you for your time and attention as a committee and welcome any questions or dialogue.

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Mr J. Wilson: Thank you for coming down from God's country and making this representation. I have a stake in that area of the province also. I was just wondering whether while you are here we could ask legal counsel, through the parliamentary assistant, if she has any cursory comments on the suggested wording as outlined in point 4.

Ms Bohnen: I will just make a couple of comments on items 3 and 4, although I think it is really dangerous to comment before these hearings are completed, so this is really very tentative.

Mr J. Wilson: We understand that. You are covered. We will not hold you to it.

Ms Bohnen: I will just raise one concern I would have with item 3, extending it to "regarding a medical, dental or optometrical disease, dysfunction or disorder." The intention of the governments has been to really focus on the kinds of diagnoses medical doctors make, and there is common law that helps us to define what the scope of practice of medicine is and therefore what medical diagnosis might be. As soon as you start referring to dental and optometrical, and I think you would have to extend that in this framework to psychological and so on, you are starting to expand rather than confine the scope of the controlled act, which I do not think would be your desire to an amendment such as this.

Also, I think you might ask: "What is a dental disease, disorder or dysfunction? What is optometrical?" I am not sure the adjectives are modifying the right nouns. Those are just some preliminary comments. The second suggestion, as was clearly said, is that it really focuses on harm resulting from people being misled as to the qualifications of the provider. The review thought there had to be protection both against confusion and diagnoses provided by people who were just not qualified to provide them regardless of how they identified themselves. It is one thing for the quack to pretend to be a medical doctor, but there is still a risk of harm from a quack who does not pretend to be something he or she is not, who provides a diagnosis that is outside his or her competence.

Mr Gehrels: May I comment on that, Madam Chair?

The Chair: Did you want to ask a question, Mr Wilson?

Mr J. Wilson: Perhaps you could comment on that. If I raised my voice that would be a question.

Mr Gehrels: In response to Mr Wilson's timely question, if I could comment on that, regarding item 3, "dental or optometrical," we are not fussy. The words are hard enough to pronounce, let alone anything else.

Ms Bohnen: Or spell.

Mr Gehrels: Or spell; that is right. It was not even in the spell checker, at any rate. But whether or not that is in there, we agree we are looking for a narrow definition and if taking those out works, great. Regarding item 4, I really wonder whether there is a tremendous danger from someone who does not claim to speak with particular authority such a person is not qualified with, whether that person still poses so much a danger.

To put it bluntly: "Hi, I'm a quack. I think you've got such and such and I think you should do such and such," does not carry near the weight as: "Hi, I'm Dr So-and-so. I think you've got this. I think you should do this." Of course I am not going to go around and say I am a quack: "Hi, I'm Ken Gehrels. I think you've got such and such. I think you should do such and such." Fine, that is what grandma told me too, but I am not going to put my life in jeopardy or carry on some kind of specific assessment because of what grandma, Mr Jones who has the farm behind me or whoever says. In our day and age, especially where we are so specialist-oriented, people look for that before they carry on with any specific activity. I think we owe it to the members of our province, the citizenry, to recognize that they have enough brains to do that. I think that preventing misrepresentation would carry us far enough.

The Chair: Thank you very much for your presentation before the committee today. If over the course of these hearings you, your organization or any group or individual would like to present additional information to the committee or feel there might be some helpful information, I hope you and everyone else will feel free to communicate with the committee in writing to our clerk at any time.

ONTARIO SECONDARY SCHOOL TEACHERS' FEDERATION

The Chair: I would like to call now on the Ontario Secondary School Teachers' Federation.

Ms Suddick: I am Mary Suddick. I am president of the professional students' services personnel occupational sector of OSSTF, and Neil Walker is executive assistant of the external policy department at OSSTF. On behalf of OSSTF I would like to thank you for your time. The process of public involvement is an important one and we appreciate the opportunity to be able to outline our concerns about the legislation. I shall now proceed to take you through our brief, which I believe members have in front of them.

The Ontario Secondary School Teachers' Federation is proud to number among its 43,000 members a growing number of professional and non-professional educational support services staff. Among the latter are audiologists and speech-language pathologists. They will be directly affected by the new Regulated Health Professions Act and the Audiology and Speech-Language Pathology Act. In addition, other federation members such as guidance counsellors and behavioural therapists and counsellors—in short, any member of the educational team who deals with questions of student disability, behaviour and mental health—may find their professional effectiveness impaired by provisions of the new bills dealing with diagnosis as a controlled act.

The functions of diagnosis and assessment, which are a key part of every speech-language pathologist's and audiologist's intervention to help students in difficulty, under the terms of RHPA become a controlled act whose communication is licensed. A controlled act is defined in the prohibitions section of Bill 43, paragraph 26(2): "Communicating to the individual or his or her personal

representative a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the conclusion."

As can be imagined, within the school setting speech-language pathologists and audiologists in the normal course of their activities on behalf of students in difficulty communicate their assessments to students, parents, teachers, counsellors and other resource personnel, and if necessary to administrators. Depending on the complexity of the difficulty and the extent of the resources that must be marshalled to meet it, a speech-language pathologist or audiologist may have to involve all of the above to help a child whose problem is serious. Under the terms of Bill 43 as it now stands, speech-language pathologists and audiologists would be stripped of the right to do just that.

If the terms of the bill and the related bills stand, none of the professionals touched by the RHPA would be able to function as above in a school or school-related setting, with the exception of licensed doctors and psychologists. In other words, as the bill stands, a speech-language pathologist or audiologist would be able to diagnose a disability or dysfunction within his or her professional capacity, but must seek out the services of a doctor or psychologist to communicate the diagnosis to anyone else who might of necessity be involved in the treatment of the dysfunction. It would seem on the face of it that the speech-language pathologist or audiologist would be in the ludicrous position of not being able to communicate the nature of the disorder or its treatment to the student or to the parent where appropriate.

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One can empathize with the concerns of those who have drafted the RHPA and related bills to protect the public from unlicensed charlatans and unqualified care givers who have the potential to do public harm. It is our belief, however, that it was not the intention of the government to disrupt or render more difficult the successful practices of therapy that are now benefiting some of our most vulnerable children within the school system. In fact, it has been a struggle within many boards to convince trustees that such support services are the lifeline essential to the survival and ongoing success of disabled children. Only persistent and effective lobbying by parent groups and associations in the field of special education have convinced trustees that these services are indeed essential.

In this respect, the battle is not over. The sad case of Oxford county, where trustees, squirming under tax revolt pressure, recently slashed support services for children in difficulty, including speech-language pathologists, audiologists and behaviour therapists, is a sharp reminder of the fragility of these services. They may not be necessary for the broad population of students, but they are absolutely vital for the minority of children who need them.

One can easily imagine the destructive frustration of a child, having lost access to the therapy that is allowing him or her to communicate for the first time with other children, being faced with a six-month or longer waiting period for help at the nearest clinic or hospital.

We call on the government to amend Bill 43 and/or the related bills to allow those professionals who are now functioning in a school setting to continue to do so without the impediment posed by the bills' approach to controlled acts.

Deputy Minister of Education Robert Mitton has brought to the attention of the Ministry of Health the difficulty posed by the definition of the "controlled act" within the school setting for teachers and guidance counsellors. We have attached a copy of the letter to our brief.

He contends that the prohibition of the communication of conclusions by the unregistered personnel would prevent them "from performing their assigned functions. For instance, in the Ministry of Education guideline for guidance curriculum one of the roles assigned to guidance counsellors in the intermediate and senior divisions is to 'assess students' particular social and emotional needs and make recommendations for referrals to or consultation with other staff or community agencies.'" Such referrals, involving an assessment of a "pupil's emotional or psychological disorder or dysfunction," would constitute a prohibited act.

Boards of education employ other professional personnel such as occupational therapists and physiotherapists. In addition, within the context of section 27, schools in clinical settings, all professional personnel, because of the special nature of the needs of these students, may be involved with the communication of assessments of dysfunctions that are, by definition, controlled acts. The potential for disruption of present practices with educational settings affected by Bill 43 is thus relatively widespread.

The deputy minister, Mr Mitton, to remedy these problems suggested the removal of the definition of diagnosis from Bill 178. It appears that paragraph 26(2)1 of Bill 43 perpetuates the same problem. Mr Mitton's alternative suggestion may be more acceptable, and if broad enough in scope would solve the problem for educators. OSSTF endorses his request that "education professionals be exempted by regulation under subsection 26(3)." If the exemption is extended to all educational settings, professionals in education will be able to maintain present practice, to the betterment of those students with special needs.

Thus, our first recommendation would be that education professionals be exempted by regulation from the terms of paragraph 26(2)1 of the Regulated Health Professions Act, 1991.

We believe the public interest would be served through the above amendment and the public protected at the same time through the safeguards inherent in the choice and supervision of professional personnel by the boards of education and the Ministry of Education.

OSSTF has several concerns related to title protection within the scope of Bill 44. Subsection 15(1) of the bill reads, "No person other than a member shall use the titles 'audiologist' or 'speech-language pathologist,' a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals."

To obviate any ambiguity as to whether this subsection applies to those qualified individuals working in educational settings, we recommend that the final phrase of the section, "in the course of providing or offering to provide, in Ontario, health care to individuals," be deleted. Our second recommendation would be that the phrase "in the course of providing or offering to provide, in Ontario, health care to individuals" be deleted from subsection 15(1) of the Audiology and Speech-Language Pathology Act, 1991.

Furthermore, as the title "speech therapist" is used interchangeably and synonymously with that of "speech-language pathologist," it too should be protected to avoid a potential glaring loophole in the act. As "speech therapist" is the historical designation for "speech-language pathologist" in Canada and elsewhere, and many practitioners presently hold licences and display the title "speech therapist," such protection would help to avoid any confusion among school board officials and the general public as to whether the practitioners are indeed licensed professionals.

Therefore, our third recommendation would be that subsection 15(1) be amended by the addition of the designation "speech therapist" as one of the protected titles.

In addition, OSSTF recommends an amendment pertaining to subsection 15(2) of Bill 44. The subsection reads, "No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as an audiologist or speech-language pathologist or in a specialty of audiology or speech-language pathology."

To prevent non-qualified persons from skirting the law by attempting to offer such things as audiological services within a school setting, OSSTF recommends that subsection 15(2), "Representations of qualifications," of Bill 44 be amended to read as follows, "No person other than a member shall take or use any name, title or description implying or calculated to lead people to infer that the person is qualified or recognized by law as an audiologist, speech pathologist or speech therapist."

Although it may be argued that the difference in terminology is not momentous in import, OSSTF feels that the protection of the public would be better served by the amendment of the wording.

Thus, recommendation 4 is that subsection 15(2) be amended to read, "No person other than a member shall take or use any name, title or description implying or calculated to lead people to infer that the person is qualified or recognized by law as an audiologist, speech-language pathologist or speech therapist."

OSSTF believes that these amendments would improve the legislation and recommends that the government consider them for implementation.

The Ontario Secondary School Teachers' Federation is convinced that the above suggested amendments to the Regulated Health Professions Act and the Audiology and Speech-Language Pathology Act will allow those professionals in education who are providing vital services to students in difficulty to continue to do so without their effectiveness being impaired.

At the same time, the protection of the public, which is the principal aim of the Regulated Health Professions Act

and related acts, would be better guaranteed. We strongly urge that the government respond favourably to our recommendations.

We would now be prepared to answer any questions you might have.

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Mr Jackson: Mary, Neil, welcome, and thank you for an excellent brief. I have quite a few questions but I know time does not allow us. There is no reference to the Ontario student record here, but I would suspect, knowing protocol, that upon certain suspicions there might be an entry in the OSR and that also the act of entering in the OSR might be proof in a court of that breach as well.

Ms Suddick: Yes.

Mr Jackson: I briefly read the letter from the deputy minister, Mr Mitton. First of all, it does not have a date on it. Does anybody know the approximate date? Maybe that could be determined since it was to the ministry. Knowing that date, we could get a sense of whether or not the government considered any amendments post receipt of the letter or if, as the letter indicates, it clearly states for the record that, "Both this ministry and the Ontario Teachers' Federation do not seem to have provided input as to the serious and broad-ranging impacts which the legislation as proposed would have on the delivery of educational services in this province." I quote directly from the letter of Mr Mitton to the Deputy Minister of Health, Dr Barkin.

The Chair: Mr Jackson, it is time for questions.

Mr Jackson: I am making it abundantly clear, Madam Chair, that we would like an answer. According to this letter, Education was overlooked. We have a letter from the deputy minister, the second-highest-ranking individual in the province in education, as far as the government is concerned, expressing concern that they were not consulted.

The Chair: Mr Jackson, do you have a question?

Mr Jackson: I have stated the question and I was about to finish until the Chair was demanding clarification on my question.

The Chair: There are four minutes left entirely and I have four speakers.

Mr Jackson: Do you know the questions I have, because I think legislative counsel knows my questions?

The Chair: Would you like to respond, Mr Wessenger?

Mr Wessenger: I will have ministry staff respond to this matter of the letter.

Mr Burrows: To answer Mr Jackson's question, we would like to be able to table the response to that letter, but it by and of itself raises some questions. It is not signed and it is not dated, so we have no way of knowing that this in fact was a letter that was sent. We would like to look at the circumstances of the release of the letter and any possible response, but we would have to check with the ministry as to what we were actually responding to. If you could leave that with us, we will do that.

I would make a couple of general comments. Looking at the content of the letter, it apparently was received prior

to the deletion of the harm clause, so my guess would be that it is somewhat dated. Second, prior to the introduction of the legislation, the entire package of course went to cabinet, at which time it was a cabinet decision to proceed. That is why the legislation was introduced. There is a consultation process that is part of the cabinet approval process and this legislation did go through that, so there was opportunity for comment. Last, at the bureaucratic level, I can assure everyone that we have discussed the legislation, some parts of it in great detail, with representatives of a large number of ministries including the ministry in question.

The Chair: Thank you very much. Question, Mr Beer. One minute.

Mr Beer: Perhaps more by way of something we could do in that week of the 16th. Given this letter and assuming that it is as it is, we could perhaps add officials from the Ministry of Education to talk about this letter and whether their concerns around the diagnosis clause remain the same or have been met.

The Chair: Your request is noted. Thank you, Mr Beer. One minute, Mr Martin.

Mr Martin: Mine is of the same nature, and that would certainly serve to—

The Chair: Thirty seconds, Mr Hope.

Mr Hope: Since I have been on this committee dealing with the audiologists and the speech-language pathologists, are there not current laws dealing with people under a certain age about hearing? Are not some of the comments currently under law that are expressed here today? The dispensers were saying about laws that are already in place dealing with a certain age for hearing and for speech.

Mr Wessinger: I will refer that to counsel.

Ms Bohnen: That particular question you are raising is not something I could honestly say I know much about, but I would be happy to look into it and report back. I will just have to get back. I do not know.

The Chair: Thank you for your presentation and for appearing before the committee today.

I remind all members that during the time that is available for questions, if you have long questions and wish a response from the ministry, you can also do that privately to the representatives from the ministry and they will then respond in writing, on the record, at the appropriate time.

JOHN CHIN

The Chair: John Chin, please come forward. You have 10 minutes for your presentation.

Dr Chin: I am Dr Chin, a consulting surgeon at two hospitals, one in Toronto and one in the suburbs. I am a practising surgeon in this city.

I have read Bill 43 and I could not find anything that relates to my concerns. I have two areas of concern. One is that the board of directors of community hospitals is not accountable to anybody or even to the Ministry of Health. They are an autonomous group. They practise with immunity from any complaints whatsoever. This is my experience. The second concern is related to section 34 of the Public Hospitals Act. I will give more details as I go along.

As I said before, boards of community hospitals are not accountable even to the Ministry of Health. Perhaps it is best to give some examples. In recent years, three hospitals boards refused to give the applicant a hearing despite the fact that the Public Hospitals Act states quite clearly that the applicant is entitled to a hearing before the board, if requested. Three hospital boards decided not to give the applicant a hearing. Even the government failed to persuade the hospital to do so. The Hospital Appeal Board is ineffective in this regard. It does not have jurisdiction to order the board to give a hearing. Even the government failed in this regard. The hospital boards, as I said, are not accountable to anybody. They are a law to themselves.

One hospital board even ignored complaints of matters of serious concern regarding health care matters and irregularities, so much so that complaints were made to the government. No response was given by the government in this regard, so I have to conclude that the hospital board is autonomous, as I said before, and not accountable to anybody.

Also, if you suspect conflicts of interest at hospital boards, to whom do you turn? The chairman of the board ignores all your letters. What do you do? To whom do you complain? Do you complain to the government? They are very ineffective in this regard.

There is even collusion between hospital boards when they want to reject a candidate. Do you know how this comes about? There is a leakage of confidential, false information from one hospital board to another hospital. How is this possible? Because two hospitals appoint the same physician chief of the department in both hospitals at the same time for two years. How can that be? It is unprecedented. How can two hospitals employ the same physician to be chief of a department at the same time for two years? Because of such a situation, leakage of information went out from one board to another to defame the candidate. When you ask for an investigation about this matter, the hospital board refuses to investigate. It is none of their business. You have to take it to court.

The chairman of the hospital later found it necessary to correct the false information, but only after the damage had been done already to the candidate. What good is that now, when the damage had already been done? This gives you an example of what hospital boards can do without any accountability.

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I know there is a debate about doctors not sitting on hospital boards. That does not solve the problem. Doctors should sit on hospital boards, but they should not be in private practice. What is needed is not so much doctors on the board; what is required is government representation on the board. The government should have someone represent the government on the board, or even the chief executive officer's appointment should be approved by the government. That is the only way the hospital board can function effectively. Taking doctors off the board is of no consequence whatsoever, because the board can still be influenced by the doctors. The doctors have their own interests; the board has its own interests.

What is shocking to me in this is that the government gives millions of dollars to the hospital, a global budget. I have information that one hospital spent 90% of the budget on salaries alone, and only 3% on equipment. How can a surgeon keep up with the latest technology? How can you get to do a laparoscopic cholecystectomy—I am sure most of you have heard about laparoscopic cholecystectomy—which only costs about \$100,000. You cannot even get that because the bulk of the budget goes towards administration. The administration takes a big portion of the budget. Even a special secretary in the administration—some are getting \$120,000. I cannot even imagine what the executive director is getting. I am sure they are over \$250,000, most likely.

That is so because the government has no input whatsoever. They give the money and tell the hospital to do what it wants to do with it. How they spend it is up to them. As long as they are accounted for, they do not care. The government has no input whatsoever. That could never work in a business at all. You cannot just give millions of dollars and tell them to help themselves to salary increases, to whatever they want, an exorbitant amount. Nobody is accountable to anybody. That is the situation right now. You read in the papers about, "It's not money." Of course it is not money; it is mismanagement in the middle level. They are giving themselves exorbitant salaries. They do not have to be accountable to anybody. Why do doctors not complain? Because they have an interest themselves to protect. They do not care. Why should they bother? Why should they worry about what the chief executive officer does? They are rather interdependent in some ways.

What I advocate is this: The government must have representation on the board. For that matter, appointments of chief executive officers should be approved by the government.

Let me run on to the next area of concern. I am running out of time. Section 34 states quite clearly that every physician has a right to, is entitled to apply for privileges. It is very misleading. It is unjust. It puts the candidate to unnecessary expenses and unnecessary harassment because it gives a false sense of success. We have no chance whatsoever. All a hospital has to do is say, "The complement is full." Who says the complement is full? The doctors themselves. "The house is full." One chairman said, "They don't want to share the pie." It is as simple as all that. They do not need to give another reason to tell you how they can reject you unfairly. All they have to say is, "The complement is full," and you cannot do anything to anybody.

To go further, if they are not satisfied with that, do you know what they say to you? They give you a hearing after giving away the job or they refuse to give you a hearing. One president of a hospital was asked this question, "Three plus one is what?" She refused to answer because it comes to four. She testified in court that the proper complement was three when in fact it was four. That gives you the extent of what the president of a hospital will do to protect the doctors. Of course, in turn the doctors protect them too, sort of vice-versa.

What about the appeal board? It is only a rubber stamp. They go further. In fact, they give more reasons than the hospital give if you go to them. Also, to give you an example, the Hospital Appeal Board gives you what reason? Personality. The hospital never brought it up, but people will say personality to give the hospital a lending hand.

Also they fail to provide a transcript to the court if you want to go to court and appeal it. You have to fork out thousands of dollars, \$5,000 to get a transcript if you want to go to court and yet it is stated quite clearly in the Public Hospitals Act that the hospital people must provide a transcript if it is not part of their transcript.

If you go to the court, the court punishes you. If you ever say, or your lawyer ever says, that the Hospital Appeal Board is biased you will get hit for it. You will get charged for client as well as solicitor's fee to punish you. That is why this act should be taken out. It is useless. No special candidate to my knowledge has ever successfully applied and got in. If the hospital wanted to check you, there is a foolproof answer. There is nothing you can do about it.

This act needs changing. It is a futile exercise. It causes unnecessary expense to the candidate. It is time the government did something about it. To summarize it all, the hospital board should be made accountable to the government or government should put a representative there to see how its money is spent. Otherwise, things will never change. Taking doctors out of the board is not the answer.

The Chair: Thank you very much, Dr Chin, for your presentation before the committee. The committee is dealing with the Regulated Health Professions Act. Your representations were with regard to the Public Hospitals Act. We are aware that the Ministry of Health at the present time is reviewing the Public Hospitals Act and as chairman of this committee, I will undertake to ensure that the Hansard of your presentation as well as your documentation is forwarded to the Minister of Health for consideration as part of the deliberations around the new Public Hospitals Act.

NATIONAL COUNCIL OF CANADIAN FILIPINO ASSOCIATIONS

The Chair: I would like to call next the National Council of Canadian Filipino Associations. Welcome. I know you have appeared before a number of committees. I do not think I need to tell you how to proceed. Please introduce yourself. You have 20 minutes for your presentation and we would ask if you would, Carmencita, leave a few minutes at the end for questions from committee members.

Ms Hernandez: My presentation is short but hopefully concise. I would like to thank the members of the standing committee for giving me the opportunity to present our views on Bill 43, the Regulated Health Professions Act. My name is Carmencita Hernandez. I am the regional vice-president of the National Council of Canadian Filipino Associations. The NCCFA is a federally incorporated organization representing its member associations across Canada. Formed in 1963, the NCCFA aims to contribute to a viable, visible Filipino Canadian community that can

actively participate in the social, cultural, political and economic life of Canada.

We strive to serve as an effective voice of the Filipino Canadian community. We are committed to working towards the development of a strong community, proud of our heritage and active in the building of a just, humane and prosperous Canadian society. As individuals, we are also members of the Ontario Coalition of Visible Minority Women, the Toronto Organization for Domestic Workers Rights or Intercede, the Network of Filipino Canadian Women. NCCFA is a member organization of the Canadian Ethnocultural Council, a coalition of 37 national ethnic organizations across Canada.

As the regional vice-president in part of Ontario, my mandate includes campaigns, projects, programs and activities and development of policies on issues such as accreditation of foreign credentials; employment equity; education equity; wife assault, sexual assault and violence against women; AIDS; access to health and social services; and systemic discrimination. These campaigns, projects, programs and activities are a result of our collective work in the community as workers, as community leaders and representatives, as community activists, as Canadians. Our work is framed by the principles of equity, equality and justice. This is strengthened by our recognition of our contribution to the economic, social and cultural and political growth of this province and country. It is steered by our commitment to a just society.

1520

Striking a New Balance: A Blueprint for the Regulation of Ontario's Health Professions presents the recommendations of the Health Professions Legislation Review. In the overview of the recommendations, under the subhead "Mandate", it states that the review was created at a time when much pressure for change to the existing regulatory legislation was being exerted. It appears, however, to have missed the concerns of individuals, community groups and agencies for accessibility to health services and for health professionals and health service providers to reflect the diversity of this province.

The participants and others in contact with the review fail to include women's groups, including immigrant and visible minority women's groups, ethnoracial organizations and community health clinics. It seems to me that a balance could not be struck without representation from the abovementioned constituencies.

It is very important to recognize certain institutional barriers that face foreign-trained health professionals. I am certain that the members of this committee are familiar with the report entitled *Access*, a report of the Task Force on Access to Trades and Professions.

Bill 43, as presented, provides for the establishment of an advisory council, section 7, and the Health Disciplines Board, section 17. It is very important that the members of this council and board be representative and reflect the diversity of this province.

With reference to schedule 2, the Health Professions Procedural Code, we strongly recommend that section 9 also include committees on equity in health education and practice and accreditation. This would encourage different

colleges to adopt policies and establish programs that will acknowledge the diversity of their community and make a commitment to fair treatment and opportunity for all Ontario residents.

There are also certain requirements that have to be met before an application for registration is even received. The experiences of foreign-trained nurses in their attempt to be registered in this province are well documented by the Coalition of Visible Minority Women and other organizations such as the Filipino Nurses Association.

We would like to ask that there be provisions in the code that would also allow third-party representation on behalf of applicants rejected, and not only when an applicant dies or becomes incapacitated. I hope this opportunity given to us would serve as a first step in reaching out to the various colleges.

Mr Beer: Thank you very much for your presentation. I think you have touched on a number of issues, but one, I believe for the first time, relates to the procedural code and your suggestion that perhaps there should be a committee dealing with equity. I know certainly in other forums many people have said that this issue of employment equity is perhaps one of the most critical. Do you have any sense whether, in the deliberations that are still going on with respect to the Task Force on Access to Trades and Professions, consideration is being given to this particular point you made?

Ms Hernandez: Yes, this is part of the demands for the new government, to act on the recommendation of the Access report, a recommendation to install a plan which is the pre-learning assessment network. It is being asked for by communities. I believe there are initiatives, but we do not know about the details.

Mr Beer: Would it be fair to say that regardless of what initiatives come out of the government response to that task force, you would still think it useful to have a committee on each of the councils that dealt with this process?

Ms Hernandez: Definitely, because we see that there is resistance among colleges to address the issue even of gender equality, and much more so in race equality. The establishment of accreditation or equity in the health profession, in terms of practice and education, would be very useful. It is opening up their minds to the different composition of this province. We are very aware there appears to be resistance to acknowledging the fact that as immigrants come to the country, we bring along our credentials, and maybe what is needed is a different kind of program that would help us adjust to the profession we would like to practise.

Mr Jackson: Mr Beer has asked some of the questions I wanted to ask, but going further on this issue of employment equity in the health professions, it is my understanding that the native community will at some time be presenting to this committee its concerns with respect to self-government and separate colleges for native people because of that model. That is not what you are requesting. You are requesting an equity access model within the existing framework of the regulated agencies. Do you

support—this is a question I will ask the minority women's group who are coming next—native Canadians with respect to their request for separate, independent colleges for purposes of graduating, regulating and training their native health professions?

Ms Hernandez: We support the call of the native people, even asking for their own justice system, and we believe they are very right in asking for their own colleges to be able to train and give credit to their professionals.

The Chair: Thank you very much for your presentation. The committee appreciates hearing from you. If, over the course of these hearings, there is anything further that you feel would be of assistance to committee members, I know you will communicate with us in writing.

ANNETTE DILLON

The Chair: Annette Dillon: Welcome to the standing committee on social development. You have 10 minutes for your presentation.

Ms Dillon: I am not from the minority women's group. I am speaking primarily as an individual. That was the understanding I had when I made the appointment. I am a little concerned by the last speech, in more of an organizational approach.

The Chair: Please relax and be comfortable. The committee is hearing from individuals as well as from groups and organizations. The only difference between you and the previous speaker is that they had 20 minutes because they are an organization. You have 10 minutes as an individual and we are here to listen to what you have to say. Just relax and tell us how you are feeling.

Ms Dillon: I am coming as an individual, even though I am working for an organization that would be affected by this legislation. I have seen the report. It is primarily the harm clause and the diagnosis clause I am concerned with.

Many years ago I had problems, which I realize now are generally termed as being part of a dysfunctional family. If one person has a problem, it is not just that person—that they are schizophrenic or something—it is the whole system that has an error in it.

I did not get help then. I was sexually assaulted by a psychiatrist. That was my first experience. I know there is some legislation to protect you against that, but that was the first problem. The next time I tried to seek help, I was referred by a family doctor to a psychiatrist, who insisted that I had to take drug therapy to see her. I went to her for one session and I chose not to see her again, partly because some of the original problems resulted from early experimentation with drugs, and I knew instinctively that this is not the answer.

About four years ago a friend suggested I try someone, whom I only saw because I heard that she was a feminist, socialist doctor, and I thought that was the combination I needed, somebody with medical knowledge who could find out what medical problem I had, and someone who was a feminist—it is men's fault—and socialist because it must be to do with the political system.

I learned in a few sessions that no, I did not have any medical problems; that no, it is not men's fault, that men

are not stopping me from progressing in the world; that it is not the political system; that it was internal things, conflicts that we all have to a degree. I am discussing what is called an Adlerian approach which is an educational model, not medical, that these people do not have mental illness, but they lack education.

The main thing the institute does is parenting programs, the idea that it is just errors in training; in my case lack of self-esteem, all kinds of things relating to dysfunctional family, including alcohol dysfunction.

1530

In any case, it did not take long. A few sessions and I had my house in order and I have got on with life. Even coming here is probably a step in that. Years ago, I would have never spoken out. Coming from the sort of family I did, I just would not have done it. So that is a sample of improving.

In any case, the reason I am here is because it did change my life and it is changing the lives of people who are using this approach. I am also a supporter of other humanistic approaches—Rogerian, Gestalt, all of these things—but I am primarily knowledgeable and have had experience personally with the Adlerian model.

My concern with the legislation is that a lot of the people who are doing this kind of counselling have an MA degree, specialized in counselling and psychotherapy. It is an intensive degree that covers all areas: family and marriage counselling, individual counselling, substance abuse counselling. They are highly trained. Yet none of the doctors I went to recognized that I came from an alcoholic family. They did not clue into it. They were not able to assess that. The referrals that were made were not good. The medical doctors themselves do not have training. Really, that is the issue, and this legislation is handing it back to doctors. It is saying that medical doctors are the only ones who can make a diagnosis, again along the lines that it is a medical model, that there is some kind of medical problem that has to be diagnosed.

My concern really is that in a courtroom, people with an MA degree can be discredited easily by a psychiatrist. I have given an example here that could apply where someone is accused of rape. If it was an Adlerian counsellor who had, through the lifestyle analysis, analysed that they have a belief that women are dangerous, which could lead to feeling that they have to protect themselves against women, overcome women, that could be a sample. But that could be discredited in court by a psychiatrist who says, "No, the person was temporarily insane and he has an organic schizophrenic disorder," or something like that. I was diagnosed as latent schizophrenic, psychotic, all kinds of things, which I realize now was just absolute garbage and absolutely damaging to me. Fortunately it is not a problem any more.

Right now I know it is going on, coming from my family. A sister currently is in and out of addiction centres in the United States, all paid for by OHIP, but every time she comes out, in a month or so she is back. There is no follow-up treatment. She is not from Toronto and there is nothing in the area she is in, and these are all areas where recovering addicts themselves who have certificate

programs, for example, can help, but that help is not getting to people. That is a main concern. This legislation seems to be perhaps not entirely responsible for that, but still, taking away the ability for someone—let's say a nurse who also has a master's degree in substance abuse counselling. She could, I am sure, run a clinic with other counsellors and help these people.

Those are basically the areas I wanted to touch on.

The Chair: Thank you very much for your presentation. The committee appreciates your coming forward today and telling us how you feel about this piece of legislation. Your presentation will become part of the public record, and if over the course of the hearings you think of anything else that you think the committee should hear, please just write to us, and we would be interested in hearing from you.

ONTARIO COALITION OF VISIBLE MINORITY WOMEN

The Chair: I call now on the Ontario Coalition of Visible Minority Women.

Ms Prescod: Good afternoon, everyone. Thank you for having me here. My name is Elaine Prescod. I work for the Coalition of Visible Minority Women as a project manager and co-ordinator.

The Coalition of Visible Minority Women lobbies and advocates for changes in legislation policies and issues that impact on the lives of immigrant and visible minority women in the areas of housing, immigration, education, racism and sexism. Those are just a few of the issues we deal with on a daily basis.

We are presently conducting a language skills training program to allow foreign educated and trained registered nurses and health care professionals, through English as a second language instruction, to prepare for the test of English as a foreign language and test of spoken English exams—these exams are part of a series of requirements and criteria needed before they can be allowed to upgrade their skills to meet the required standards for re-entry to the profession—and to become familiar with the health care system in Ontario.

An act is a binding and arbitrary law entrenched in the Charter of Rights and Freedoms. However, each bill of government deals with a particular area and becomes an act, which constitutes the laws pertaining to a particular issue. These bills are often very verbose and superficial, with a number of clauses and subsections, which make it sometimes impossible for the ordinary citizen to understand their content and implication.

Bill 43, the Regulated Health Professions Act, with a total of 91 sections and subsections, constitutes the laws and provides for the regulation of health professions and the delivery of health care service. Like all laws, it is legal, superficial and complicated. Being here this afternoon will allow me to deal with some areas of concern regarding the health care professions, with a focus on the nursing profession.

Statistics show that 61% of the professionals arriving in Canada are non-white and non-English-speaking. Approximately 45% of the immigrants to Ontario who were employable and would join the workforce were look-

ing at professional or technical categories as their intended occupation.

Fifteen or so years ago, all professionals were coming from primarily European countries and familiar locales, such as England, Australia, Ireland, Wales. This is now expanded to include significant numbers from a large number of different countries, about which generally less is known and less information is available to Canadians regarding the educational system. Quite often, the candidate's qualifications are ignored.

With this large pool of human resources coming into the country, it becomes an imperative and necessary function of the occupational bodies to easily and equitably integrate these individuals into their different professional occupations. However, it has been found that the requirements have a disproportionate and negative impact on members of minority and ethnic groups.

Under section 7, the advisory council composition: My concern there raises many questions. Why the number of five to seven? Are these members representative of the diversity and varied cultural backgrounds of the people they serve?

Under section 8, the reappointment is an area of concern. These qualifications as set out in this section regarding the qualifications of the members of the advisory committee are very negative, beginning with, "A person may not." Why not turn this clause around to become a more positive statement? It should be redefined with positive qualifications for the members of the advisory council.

The next section goes on, "Members of the advisory council are eligible for reappointment." It should clearly and specifically state the numbers of times the members can be reappointed, and if there is a lapse of time between appointments, it should be clearly defined.

The same concerns are raised with the composition and qualifications of the Health Professions Board.

They go on to say, "The college is a body corporate without share capital with all the powers of a natural person." Questions arise as to what is the meaning of the "powers of a natural person" as it relates to the college? Would it not be better understood if the wording were changed to define these powers and to give recognition to the fact that the college can have all the power and authority to own assets and also to meet its obligation?

Schedule 2, section 9: "The college shall have the following committees." A total of six committees are listed in the bill. While there is a need for committees to be set up to deal with specific areas of the function of governing bodies, there is the concern that some of the smaller occupational and professional bodies may be overburdened through a lack of human resources to serve on these committees and a lack of financial resources. Although each committee as set out in the bill has a distinct function, they can also be integrated to limit the need for a large number of statutory committees.

Schedule 2, subsection 3(2), "In carrying out its objects, the college has a duty to serve and protect the public interest." While it is the main obligation and duty of occupational bodies, whether they are authorized to grant licences or certify professionals as competent, to protect the

public interest in regard to health and safety, there must be a second obligation. That second obligation must be the policy of government to ensure that all individuals receive equal treatment and equal protection under the law, while respecting and valuing their diversity. These two factors should be contained in the bill and should be complementary with each other, not conflicting. The act as it now stands excludes the professional and seems to be in conflict and inequitable.

1540

There are some issues not reflected in the bill which we would like to talk about, such as the assessment and evaluation of credentials. Studies have shown that many immigrants are coming to the country, and as stated before, several of them have already been educated and trained and have been employed in professional and technical careers before arriving in Canada. They must undergo rigorous competency tests. If English is not their first language, they must pass the required test of English as a foreign language, or TOEFL, and the TSE, where the passing scores can vary from profession to profession, successful completion of which is a prerequisite to have the opportunity of re-entering the profession.

Some professional groups, like nursing, may take foreign experience into consideration through formal test development and validation to measure that their licensure standards or certification examinations reflect recognized standards of fairness and adequate and comprehensive appeal rights.

The present assessment of professionals can lead to conflict, doubt and mistrust. There is no concern of issues to relate to individuals of ethnocultural and ethnoracial backgrounds who are professionals. Right now the entry requirements for professionals rest largely with the certifying body. Many of the requirements for entry seem to have a greater negative impact on members of minority and ethnic groups.

Accreditation of professionals is an issue, and for those who are already trained and immigrate to Canada, what is contained in the bill to deal with the concern of accreditation? As regards registration, set out in schedule 2, the bill should contain an assessment procedure to look at the education equivalent to Ontario, with specific time of practice for immediate licensure, before being required to take re-training courses.

Schedule 2, section 21, under registration hearings: Where an applicant is refused registration, it is recommended that an appeal mechanism should be enacted into law that will allow the individual to have the right to appeal the decision or decisions. The applicant should be provided with the right to review his or her admission file before an initial decision is made. There should also be a process to appeal to the Health Disciplines Board and from there on to the Divisional Court.

What is the difference between registration hearing and registration review? This is another issue of concern. When we speak to our clients regarding a registration review, we all see a review, especially in the nursing profession, as a review of nursing documents, written transcripts and references, which are for review by a registration

committee. There should be a definite distinction for these two terms as they appear in the act.

What I have outlined in this report is from my understanding and interest in working with health care professionals who are foreign trained and educated, coming into this country and wanting to continue to work as professionals in careers for which they have trained. Re-entry to their profession on arrival in Canada is almost a nightmare for the majority of immigrants, especially if they face the greatest barrier to access and information, the language barrier.

Mr Beer: Thank you for the presentation, in particular the comments on the assessment and evaluation of credentials and the registration hearings. I believe you were present when the previous witness gave her suggestions, one of which was that there should be a committee on equity within each of the colleges. I wondered whether your organization had considered that or what your sense of that might be.

Ms Prescod: As you know, sir, Carmencita is my chairperson of the Coalition of Visible Minority Women and we work together very closely.

Mr Beer: I thought you might be in some agreement.

Ms Prescod: Yes, and I am in total agreement with that. We have been working very hard with the Alliance for Employment Equity. Both Carmencita and myself are on employment equity committees and we are therefore very familiar with the employment equity and I agree with her. That is why it was not in mine after she was going to talk about it.

Mr Beer: As follow-up, could I ask the parliamentary assistant, in the code, one of the six committees, number five, is the fitness to practise committee. I am just wondering, during the review was there any discussion that you or staff recall around this issue of equity, and was it intended that this would come under that particular committee, or was there any focus on this at all?

Mr Wessenger: I will ask staff to answer that question.

Ms Bohnen: The fitness to practise committee was very clearly intended just to deal with cases where there are allegations or evidence that a health professional may be physically or mentally incapacitated. The review felt that having a fair registration mechanism, including of course the right of review or appeal to the Health Professions Board, including regulations setting out admission criteria being reviewed by the Health Professions Regulatory Advisory Council, was the best way of ensuring all applicants are treated equitably.

If I could just add to that, Ministry of Health staff worked quite closely with staff at the Ministry of Citizenship charged with considering and implementing the Access report. I think it is fair to say and I do not think I am divulging anything to say that they viewed the procedural requirements and mechanisms set out in this legislation as quite some distance ahead of what is provided for in much other legislation that we have.

The Chair: Mr Owens, a question?

Mr Owens: Actually it is more of a statement.

I wanted to thank you for your presentation, along with Ms Hernandez. It certainly brings a different perspective and a much-needed perspective on the health professions. I think you may be aware that our government is currently working on access legislation that will help break down the barriers to professionals coming in from other countries. I think, again, that this is much needed.

I would like to request that the Chairperson send this Hansard, as well as the presentations of both Ms Hernandez and the current presenter, Ms Prescod, to Juanita Westmoreland-Traoré for her information, as our employment equity chairperson.

The Chair: That is noted, and we will have Hansard, as well as the presentations, forwarded to the commissioner for employment equity.

I would like to call now Goodman, Thomas Goodman, Pomerantz, Robinson and Associates. They are not present? All right, is Ross Johnson here? In that case, the standing committee on social development will recess and reconvene at 4 pm to hear Goodman, Thomas Goodman, Pomerantz, Robinson and Associates.

The committee recessed at 1548.

1558

GOODMAN, THOMAS GOODMAN, POMERANTZ,
ROBINSON AND ASSOCIATES

The Vice-Chair: I believe we have Warren Robinson next before us, of Goodman, Thomas Goodman, Pomerantz, Robinson and Associates. It sounds like a law office or an accounting office.

Mr Robinson: It is a psychotherapy office.

The Vice-Chair: Now that we have that straight, we can proceed.

Mr Robinson: To be precise, it is an office of two psychologists and two psychotherapists who are unregulated.

Basically I come today to just—I guess I am getting old enough almost to say “share the experience of an old practitioner,” as I had the weekend with two of my granddaughters. So I am feeling a little old. But I have worked for nearly 30 years in private practice, for the last 15 or 16 years as a psychologist, both with people who come under your definition of regulated and unregulated. I just want to share a body of experience that I have had working in this field with professionals of various types, because my fear around the legislation is that there is just too much limitation, too much constriction based on training, based on professional group, and not enough recognition of the wisdom and experience people have had from whatever areas they have obtained it, part of it being their own training and their own education.

For example, as I say, in my partnership we talk about causes of symptoms all the time and I do not have a sense that the two of us who are psychologists are any wiser than the two who are not. In fact, if you pushed me, I would probably say I have got most of my understanding and my wisdom, not from my graduate training at the University of Waterloo that led to my PhD, then to my being registered as a psychologist, but as much if not more from the various experiences I have had since then, the various

informal training programs I have had since then. Basically I want to say please understand how much goes into making a competent practitioner. It is not solely based on one's professional training in a higher educational institute.

Two things strike me right off that I would like to speak to: One is, it seems to be ridiculous to make a difference between assessment and diagnosis. As I read it and reread it, it seems to me any trying to find some legal definition is hedging words. Diagnosis and assessment are a professional's competence that comes to bear on understanding what a person's problem is and understanding how to best go about alleviating that problem. To try to say one group can be assessed and the other group can use diagnosis, to me, will run into a lot more problems than it will solve. To me, they are basically the same.

It also seems to me that to limit diagnosis of any particular condition to a single professional group is a mistake. For example, over the last six or seven years I have been suffering from high blood pressure. I went to my physician and he said, “Here, I have some drugs for you to take.” I said, “What causes high blood pressure?” He said: “We don't know that. For ninety-five percent of the people who have high blood pressure, we do not know what causes it.” I said, “That's a rather strange thing.” He said, “That's just the way things are.” So I said, “I want to get a second opinion and a third opinion about what I can do about my condition.”

I went to another physician who has a lot of training in homeopathy and naturopathic medicine and he said: “We're finding that an awful lot has to do with the kidneys, and from other assessments that I make of you, like the white spots in your fingernails, I think you have too much yeast in your system. When you have too much yeast in your system it constricts your kidneys and will increase your high blood pressure.”

I said, “That sounds like a reasonable plan.” I went to a dietician and she said basically the same thing. So I worked together with the dietician around my own diet and, lo and behold, my blood pressure went down to a normal level. These people diagnosed it and I would want to encourage you not to throw out the ability of people from other lines of work to really see truth, to really see how things work. I think people are very wise about how to use Bach flower remedies. In the field of psychotherapy a lot of understanding has come out in the last 10 years about abuse that I did not learn about in my professional education.

A lot has come out in terms of addiction and the impact of shame upon people's lives when they have had early childhood experiences that have induced shame. A lot of people who I refer to have done a lot of study and have done a lot of work in this area and have read people who have done outstanding work around shame and addiction. I find that I refer people for specific work quite often to people who are unregulated who have had really up-to-date knowledge and experience around new things that are developing in the field of psychotherapy.

You have, particularly in the city of Toronto—I cannot speak for all of Ontario—a very talented body of unregulated practitioners. I think it would be a mistake to say,

"Psychologists, or physicians or whoever really have the bottom line and really know how to deal at the core of your problem," and to tie the hands of these people to really do what they can do well. There are a awful lot who do a lot of beautiful, wonderful work.

The Vice-Chair: Can I just interrupt, Mr Robinson. Please forgive me, I forgot to mention that you have 10 minutes for your presentation. If you would like to allow some time for members of the committee to ask questions, you have about three or four minutes left.

Mr Robinson: Fine. I do not have that much more to say. I am not here to present a well-documented brief. I am really here to present my experience and what I have brought to bear from my practice, so I will finish it up in another two minutes.

Basically I would recommend that there not be any difference made between assessment and diagnosis. If you need to deal with the issue of diagnosis, I can understand the need to have some teeth in the legislation that would deal with people who are either going way beyond their level of competence or who are incompetent to deal with whatever problem is coming up. That would make sense to me. I think the Coalition of Unregulated Practitioners has done a good job in terms of providing some alternative solutions. I certainly would recommend something around proposal 2 that they have presented to you, some wording that states that those who are really going far beyond their level of competence need to be controlled. I have no problem with that. In fact, I support that.

But I think we need to decide on an individual basis whether a given person, based on his own training and the experience he has brought to his work and reputation, is operating within his level of competence or not, and not based on whether he has a particular degree, MD, PhD or whatever, or a psychologist or a non-psychologist, not to rely on that as the sole criterion. I certainly agree that people should not call themselves psychologists if they are not psychologists. That needs to be there as it is in the present legislation. But not in terms of competence.

I think that is the essence of what I have to say. I just want to again encourage you not to tie the hands of the great number of wonderful professionals we have who are unregulated in Toronto.

The Vice-Chair: Thank you for your presentation. Unfortunately we have run out of time and will not be able to allow for questions at this point. I thank you for appearing before us.

ROSS JOHNSON

The Vice-Chair: I call on Mr Ross Johnson. Welcome to the committee. I should point out that you also have 10 minutes to make your presentation. If you would like to leave some time for questions, that is entirely up to you.

Mr Johnson: I come from the other side of the fence from Warren in that I am not licensed. I am not a registered psychologist. I have a master's degree in psychology and I have been practising psychotherapy for about 20 years. My background includes working at the Dellcrest Children's Centre for about seven years as a front-line

worker, supervisor and trainer. Since that time I have had a private practice and have been involved in teaching psychotherapists in training who have included people with MSWs, MA psychologists like myself, MDs and registered psychologists.

What I want to say is that although I support the major thrust of the RHPA, my big concern is around paragraph 26(2)(1), which is the diagnosis clause and the one Warren was referring to. My concern about that is that even though I think it is very important that unscrupulous practitioners not be allowed to practise and that it is important that incompetent practitioners not be allowed to practise, I think, as Warren said, there are a lot of very competent unlicensed and unregulated practitioners whom this legislation, I think, would put at undue risk.

I am certainly not asking for anything that would make it easier for me and my group, the unlicensed group, to get away with things that the licensed group could not get away with. I think it is important that not happen. But on the other hand, I think the legislation is going too far the other way. Maybe it is an overcorrection or whatever, but it feels like it is placing the competent unlicensed practitioners at undue risk.

I have not written in my letter, but I recently trained as a Shiatsu therapist. Shiatsu therapy is a pressure point therapy, mostly using thumb pressure, developed over a couple of hundred years in Japan. The heritage is Chinese medicine. It appeals to me and I have enjoyed the treatments I have had and I believe it is very helpful for people receiving the treatment.

My concern about the legislation is it will place what might be termed as the natural healers also in jeopardy for making diagnosis and for treating people. I think there is a whole group of people in our society who believe it is important to look after one's own health. I think the eastern tradition is that; one has a responsibility to eat properly or exercise properly to look after one's own health. I have some concerns the legislation will reduce the opportunity of people getting that kind of advice and learning. I think that is all I want to say right now.

Mr Hope: I guess we are trying to play with this issue of communication, of diagnosis. How do we stop those who are not capable of performing a job in the unregulated sector? They may take advantage of individuals, and the legislation is to protect people. Keeping in mind there are the professional groups and the non-professional groups, it is the general public in larger centres such as Toronto and other larger centres throughout Ontario where there is an ability for more cases to pop up, whereas in rural Ontario we kind of know where each other comes from. We hear what you are saying about trying to make sure there is still some type of protection for people.

Mr Johnson: Are you asking me what the wording might be?

Mr Hope: In your own terms, so that you are clear. Are you part of the ones that are unregulated?

Mr Johnson: Yes.

Mr Hope: We all have to have it clear in our minds what the wording ought to be. I only bounced it off you

now in case you have a quick response. If you do not, I would like to hear back on that because it is important we all understand.

Mr Johnson: I think the legislation should have the same kind of expectations of unregulated as of regulated and I do not know how that might be included—maybe the people who have drafted this legislation could come up with some wording—but I think it would be possible to have wording that would allow a person who has gone for help to somebody who is basically grossly incompetent to have easy access to some kind of courts to deal with their misuse or abuse by the unlicensed practitioner.

Mr Owens: My question is to staff, through the parliamentary assistant. I think Mr Johnson raises an excellent point about line workers in group home situations and especially children's mental health settings where they are called on to make assessments and diagnose issues and also communicate those assessments to parents. I am wondering why the psychologists, the MAs, were left out of this particular piece of legislation.

Ms Bohnen: The review, of course, recommended that the profession of psychology continue to be a regulated profession. Currently in Ontario the issue of who gets to register as a psychologist has been determined by—I believe it is set out in the Psychologists Registration Act and the governing body is the board of examiners and psychology and it is indeed restricted to psychologists who have PhDs.

The review knew there was a large occupational body, those with MA qualifications, who very much want to be eligible for registration—I think they are on the agenda for tomorrow—but the review felt that what we are doing has

to do with what profession should be regulated under what structure.

The issue of who should be able to register as a member of the psychology profession is not to be dealt with at this stage, but at the next stage of the process which is the writing of the regulations under the new act which will set out what the criteria are for registration as a psychologist in Ontario. It is not that the review said, "No, you people should not be able to register." It is that the review said, "That is a second-stage issue, not one that we are looking at."

Mr Owens: In terms of how subsection 26(2) will impact on practitioners like Mr Johnson with respect to the communication of a diagnosis, which he is essentially doing, where is that going to leave that person?

Ms Bohnen: I would not necessarily conclude that is what he is doing. I think the central core of the issue the committee has been struggling with so far is trying to think of language that might differentiate between the kind of diagnosis physicians do and the kind of assessment—I will use that word—that many other care givers, social workers, psychometrists, psychotherapists provide. So I think the first issue is trying to carve out a distinction between the two. If you are still concerned that this distinction is not clear enough to give comfort, then another issue would be considering things like exceptions for definable occupational groups.

The Vice-Chair: I am afraid we have run out of time. I would like to thank you, Mr Johnson, for making your presentation today. We are adjourned until tomorrow.

The committee adjourned at 1621.

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Wednesday 21 August 1991

Standing committee on social development

Regulated Health
Professions Act, 1991
and companion legislation

Assemblée législative de l'Ontario

Première session, 35^e législature

Journal des débats (Hansard)

Le mercredi 21 août 1991

Comité permanent des affaires sociales

Loi de 1991 sur les professions
de la santé réglementées
et les projets de loi
qui l'accompagnent

Chair: Elinor Caplan
Clerk: Lynn Mellor

Président : Elinor Caplan
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON SOCIAL DEVELOPMENT

Wednesday 21 August 1991

The committee met at 1004 in committee room 2.

REGULATED HEALTH PROFESSIONS ACT, 1991, AND COMPANION LEGISLATION

LOI DE 1991 SUR LES PROFESSIONS DE LA SANTÉ RÉGLEMENTÉES ET LES PROJETS DE LOI QUI L'ACCOMPAGNENT

Resuming consideration of Bill 43, the Regulated Health Professions Act, 1991, and its companion legislation, Bills 44-64.

Reprise de l'étude du projet de loi 43, Loi sur les professions de la santé réglementées et les projets de loi, 44 à 64, qui l'accompagnent.

ONTARIO ASSOCIATION OF CONSULTANTS, COUNSELLORS, PSYCHOMETRISTS AND PSYCHOTHERAPISTS

The Chair: The standing committee on social development is now in session. I would like to welcome everyone this morning. I call our first presenters, from the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. Please come forward and introduce yourselves to the committee. You have 20 minutes for your presentation. We ask if you will please leave a few minutes at the end for questions from committee members. Welcome. Would you please begin your presentation now. The committee members have all received copies of your written presentation.

Ms Moroney: I am Elaine Moroney, president of the association. I am joined this morning in our presentation by Rick Willick, the chair of our public policy committee, Laura Mestelman and Leslie Langdon. We thank the committee for this opportunity and commend the Minister of Health for moving forward with the Regulated Health Professions Act and its companion legislation, particularly Bill 63.

We would be remiss if we did not acknowledge the contribution, leadership and direction of Mrs Caplan, the former Minister of Health, in this very long process. As well, we would like to publicly acknowledge the patience, co-operation and assistance of Ministry of Health staff during the past number of years, particularly Mr Alan Burrows and Ms Linda Bohnen.

The Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists is a provincially incorporated professional association established in 1978 to serve as the representative voice for non-registered practitioners in the field of psychology.

Our membership consists of approximately 400 individuals who are trained in psychology and related fields. Their current professional responsibilities include psychological assessment, counselling, various forms of psychotherapy, teaching, behavioural intervention, consultation and research.

We work in a variety of settings with a sample breakdown as follows: 31% of our members work in schools, 23% work in hospitals, 13% work in mental health clinics, 12% work in private practice and 7% work in colleges and universities.

Our members are mostly the non-PhD service providers, with 90% having at least a Master's level of training and an additional 8% having at least a Bachelor of Arts preparation.

We are a female-dominated group within psychology, with 68% of our members being women. We have been active in this process because our specific concerns have not been satisfactorily addressed by the Ontario Psychological Association nor the Ontario Board of Examiners in Psychology during the almost 10-year review process.

Our members provide services to the public under many titles because we are prohibited by the current Psychologists Registration Act to use the terms "psychologist," "psychological" or "psychology," although we are trained in psychology, although many of us work in professional positions within psychology departments and services, although our professional responsibilities are often identical to those of our registered psychologist colleagues and although colleagues with equivalent training are eligible for registration in psychology in half the provinces of Canada and in many countries throughout the world.

Data from the 1980 Canada census and our own employment surveys indicate that approximately two-thirds of all providers of psychological services in Ontario are not regulated under the present legislation. For example, a recent survey of psychological services provided within Ontario government ministries, including psychiatric hospitals, indicated that 62.5% of the practitioners providing service are non-registered providers.

OACCPP believes that the present legislation governing psychological services does not adequately reflect the reality of psychological service provision in Ontario. We have been disenfranchised from our profession even though we deliver the majority of services to the public.

The new health professions legislation must provide for regulations which will ensure that the proposed college of psychologists includes non-doctoral providers of psychological services as participating members with equitable representation on the board of the college.

What we are seeking is regulation rather than supervision, and we do so for the following reasons. Supervision means that a registered psychologist stands between a non-registered provider and the college. Supervision can be merely nominal, as it usually is, or strict, depending on the needs and perspectives of the individual supervising psychologist. In a number of situations, the skills and experience of a non-registered person may be superior to those of the supervisor because of specialized training and more

extensive experience, but we still must be subservient to the registered psychologist. Therefore, there is a danger that such skill and experience could be lost, to the detriment of the consumer and the taxpayer.

1010

I share with you my own personal working experience in the area of deafness. I was hired over a number of registered candidates because of my specialized background, training and experience. I, like many of my colleagues, work independently. I consult with school staff, parents and the child. I determine assessment questions, develop and conduct a test battery, analyse the data, draw conclusions and write the report. However, under the current situation, I must then have that report co-signed by a registered psychologist who has never met or seen the child or parents involved. I would like to add that this is not an unusual, nor exceptional, situation for people like myself. I think my colleagues here could describe working under very similar circumstances. There appears to be an assumption that I am permanently undertrained and therefore in need of endless supervision.

In addition, under the current statutory framework, the non-registered person is not subject to regulations, is not required to take part in continuing education and is not subject to the disciplinary and complaints procedures of the college, even though this group provides the majority of direct services to the public. It is for these reasons that we emphasize regulation rather than supervision.

In addition, the non-registered providers are currently denied the opportunity to participate in the discussion of ethical issues and policies being debated within the college, except as private citizens. In OACCPP's view, deliverers of fully professional and important services should be directly connected to the regulatory body of their profession. Regulation for our members would therefore more appropriately protect the public.

OACCPP supports the proposed statutes. However, we believe that non-doctoral practitioners in psychology must be included in the regulations which will ensue. We believe this is important for the protections of the public.

Therefore, OACCPP has repeatedly advocated that our members, and I should say other qualified practitioners who are not members, be included within the regulations as legally recognized members of the college of psychologists with opportunity for representation on the council and committees of the college of psychologists, with opportunity for involvement in the development of regulations for the college, with no restriction to the right of private practice in one's area of competence and with the establishment of a finite period of professional supervision after which application for registration may be pursued.

We recognize that most of our objectives will be the subject matter for the new advisory council and the regulations required to support Bill 63.

We ask the committee to support our position that the right of entry to a profession should be based on training and experience which can be measured against standards of competence to be established by the college, rather than an outdated élite approach to credentialism. It should not be a matter of who has a PhD. Rather, it should be a matter

of who is trained, experienced and judged to be competent. It is a matter of the best use of the talents, expertise and experience of people like ourselves who are already serving the public.

We are encouraged by the decision last month by the Alberta government to continue to accept master's-level providers as members of the profession of psychology in that province.

Since 1984 we have repeatedly attempted to negotiate the right of entry to the college on the basis of a fair and equitable measure of competence with both the Ontario Psychological Association and the Ontario Board of Examiners in Psychology without success. During the last two years, we held a series of meetings with OPA directly on this issue that were equally unproductive.

However, I am very pleased this morning to say that as a result of a meeting held on Monday of this week between OACCPP, OPA and OBEP we are hopeful that an amicable and equitable resolution to our concerns may be possible through the establishment of a task force to be chaired by the registrar of the Ontario Board of Examiners of Psychology. I table with the committee a copy of a joint letter to the Minister of Health outlining the proposed process. I have a copy of the letter here.

We thank you for inviting us to appear this morning and we request that this standing committee recommend that the Minister of Health, under the mandate of the new Health Professions Act, ensure that qualified non-doctoral providers have the opportunity to gain entry into the new college of psychologists.

Mr Owens: I would like to begin by thanking you for your excellent presentation and I congratulate your association and OBEP for coming to an agreement with respect to sitting down and developing a task force. I think you folks are not too far apart. This demonstrates that this legislation can work in getting the parties to sit down and work out their concerns without resorting to legal means. Again I congratulate both your association and OBEP and I will pass on the same remarks when I testify later today.

Mr Beer: I want to understand two things here. My first question will be to the parliamentary assistant. Am I right in assuming that the reason the review did not make reference to this situation was that it did not get directly involved in who would be a member of any particular college, or was there a review?

Mr Wessenger: I will refer that to counsel.

Ms Bohnen: The review was not concerned with requirements for registration.

Mr Beer: In terms of your own association, at the present time how does one become a member?

Ms Moroney: I will answer that. We have an application process. The application form requests the position the person is holding and proof of academic training. Our association is open both to bachelors and masters level people. We are a professional organization, but in the foundation of the organization in 1978 with five people in Kitchener-Waterloo, the *raison d'être* for the organization has been to change the existing structure in terms of entry to practice.

Mr Beer: Am I right that basically the only thing that is missing between the people who are members of your association and those who are currently within the college is that they happen to have a doctorate?

Ms Moroney: Well, some of our members have doctorates.

Mr Beer: As well?

Ms Moroney: Yes, some of them are all but dissertation appeal. Some of the members may not have fulfilled the present requirements for doctoral programs that OBEP makes. Some of them would have PhDs in associated areas such as a doctor of education, but working within a department of psychology as a psycho-educational consultant.

Mr Beer: Is there some clinical component that is necessary as well to become a member of the college, or essentially, if you have your doctorate in psychology, are you virtually assured of being a member of the college?

Ms Moroney: No, that is not the case. OBEP will be presenting this afternoon as well and could describe in more detail all the requirements for entry.

Mr Willick: There are master's-level members of OPA, people who in 1960 were grandfathered in and have continued to practise as registered psychologists with masters level training.

Mr J. Wilson: Thank you for the presentation. For the purposes of this committee and these hearings, do you have confidence at this point that you are going to get a positive result out of your negotiations, and do you still have a request of this committee that we include you in the bill now or, as the minister has contended, can it be done by regulation later for the non-doctoral practitioners?

Ms Moroney: Yes. Our issue is entry to practice, which is not part of the Psychology Act. It will be covered under regulations which will be set up through the transitional council of the new college of psychology.

1020

Mr J. Wilson: But a number of non-doctoral psychologists have asked if we could do it at this level rather than wait for regulation.

Ms Moroney: I am not sure that is possible within the act as it is written now.

Mr J. Wilson: Anything is possible.

Ms Moroney: What we have requested is that the Minister of Health, with the mandate she should be given through the act, can make her wishes known to the advisory council and also directly to the new college of psychology as to her approval or disapproval of regulations as they are being set, or once they are set.

The Chair: Thank you very much. We appreciate your coming before the committee today. In the course of our hearings, if there is any additional information you think would be helpful for committee members, please feel free to communicate with us in writing through our clerk.

CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION
FOR ONTARIO

The Chair: I would like to call next the Christian Science Committee on Publication for Ontario. Please come

forward and introduce yourselves. You have 20 minutes for your presentation and we ask that you leave a few minutes for questions from committee members at the end of your presentation. Please be seated and speak right into the microphones for the benefit of Hansard. We ask that you begin your presentation now, please.

Mr Fulton: Thank you, Madam Chairman. My name is J. Don Fulton. I am the Christian Science Committee on Publication for Ontario manager. We appreciate the opportunity of appearing briefly before your committee. We also appreciate the fact that you have allotted us 20 minutes. Frankly, I think our presentation will be less than 10 minutes.

I am talking on two specific points. One is the appreciation of the Christian Scientists of Ontario for the recognition or accommodation of the prayer aspect in Bill 43. This, of course, is a continuance of the health discipline accommodation of 1974 under the part on medicine. We appreciate that section 28 states treating a person by "prayer or spiritual means...in accordance with the tenets" of the religion of the person giving the treatment is recognized as acceptable.

In 1974, at the time that this accommodation was approved by free vote under Mr Frank Miller, then Ontario Minister of Health, it was understood that it was granted on the basis that healing through prayer would be in good faith; it would be in accordance with the tenets of an established church; and the practice and profession of the religion itself was to be the cure. Diagnosis did not form a part of treatment through prayer. We all realize, of course, that this accommodation has now been operative for 17 years without a single concern having been raised about its operation by the government, the Ministry of Health or the public during that lengthy time.

Copies of two court cases considered in forming section 52 of the Health Disciplines Act are in the appendices. I think one is of particular interest, appendix B, and that was a ruling made by Benjamin N. Cardozo, who was also a Supreme Court justice in the US.

In this particular case of the people versus Vogelgesang, he points out that the tenets to which the law accords freedom of practice in a profession "are not merely the tenets, but the religious tenets of a church. The profession and practice of a religion must be itself the cure. The sufferer's mind must be brought into submission to the infinite mind, and this must be the healing." The operation of the power of spirit must be direct and immediate. As I say, we much appreciate this continuance. There are a number of churches, of course, that do practise healing through prayer in Ontario.

Relating to the controlled acts, under which I have noted newspaper accounts by Dr Evans, chairman of the Coalition of Unregulated Practitioners, I want to state that section 26 in Bill 43, referring to controlled acts as it now stands, is totally acceptable to the Christian Scientists of Ontario, whom I represent. We do not consider it to be restrictive in any way since diagnosis does not form any part of the treatment of healing through prayer. At the same time we recognize the concerns those people who identify themselves as unregulated counsellors may have in their dealings with the public.

If your committee should decide to accommodate these concerns, giving the unregulated counsellors freedom from the diagnosis or communicating restrictions of section 26 entitled "prohibitions," may we suggest they be given a separate exemption dealing with their concerns. This would allow them to describe exactly what it is they want and would also free other sections from the mumbo-jumbo that could follow when attempting to define and delineate their interests in a way acceptable to all.

The Chair: Thank you very much for your very thoughtful presentation. Mr Beer, question?

Mr Beer: In a sense there really is not a series of questions because basically it would appear that the process worked and the way in which the legislation has been drafted meets your concern. Regarding your point at the end, as we go forward to deal with the unregulated counsellors, I just note that we look at doing that through some other process so as not to affect the wording you have agreed to, just by way of comment.

The Chair: Thank you very much. We appreciate your appearing before the committee today. If you feel there is any additional information you would like to share with the committee at a future time, please feel free to communicate with us in writing.

CANADIAN HARD OF HEARING ASSOCIATION, ONTARIO CHAPTER

The Chair: I call next the Canadian Hard of Hearing Association, Ontario chapter. Come forward, please and introduce yourselves to the committee members. You have 20 minutes for your presentation. We would ask that you leave a few minutes at the end of your presentation in case there are questions from committee members. Welcome. Please begin now.

Mr Ford: I am John Ford, president of the Ontario chapter of the Canadian Hard of Hearing Association.

Ms Kortright: I am Kathy Kortright, secretary.

Mr Ford: Madam Chair, honourable members, as executive members of the Ontario chapter of the Canadian Hard of Hearing Association, we are here today to bring you the hard-of-hearing consumer viewpoint on the problem issues pertaining to Bills 44 and 55. We have heard arguments at these hearings such as, "This is a contentious issue," and, "The fighting of turf wars." From the very beginning we want to make it clear that the consumer group is not taking sides in this war. Indeed, we are finding that both physically and figuratively our ears are becoming the battlefield of this turf war.

Once and for all, I want to state clearly that CHHA-Ontario's one and only interest in these hearings is to see that all hard-of-hearing people in Ontario have the resources available to provide them with the best possible hearing health care for their own lifestyle. In Ontario we have become accustomed to living with one of the best health care systems in the world and we in CHHA-Ontario are determined to see to it that the hard-of-hearing people are not going to be discriminated against by having that level reduced or limited by these bills or any other laws that the government of Ontario may try to present. It has

been a long, hard, uphill fight to get a reasonable level of access for those of us who have a hearing disability and we will jealously protect our rights to that access.

1030

In her April 2, 1991, speech to the House, the Minister of Health said: "We believe the laws that regulate health professions must be changed to better serve the public interest.... Consumers...have the right to receive health services that are competently performed...which suit their needs and desires."

We fully agree with this comment. To this end, we most strongly protest any move by the government of Ontario to limit the availability of access devices by removing the individual's right to free choice in the purchase of one's personal hearing aids.

Yes, there is most certainly a need to regulate the audiological profession. This is clear to us in that CHHA-Ontario received more complaints about the conduct of audiologists last year than we did about hearing aid distributors. No, there is categorically no justification for this government to deny hard-of-hearing citizens the right to purchase the hearing aid of their choice from the source of their choice at the time of their choosing.

Earlier in the proceedings of this hearing we heard statements from another group that they felt hearing aids were a hazardous device and thus should come under the blanket cover of the minister's definition of regulated activities. "Legislation is based on the concept of controlling potentially dangerous acts," is how it was worded in that same April 2 speech. We, as the users of hearing aids, would like to make a comment on this.

Very few of the aids sold in Ontario last year were in fact of such high power as to have even a potential for doing damage to the wearer. This danger is in the fact that the aid can be turned up too loud and could, under certain circumstances, over a period of time do some damage to the wearer's remaining hearing. To deny someone needing such a device the free access to purchase it is like arguing that there is potential danger for some paraplegics in some wheelchairs from which they could fall if not properly belted in, and therefore the government should perhaps restrict the sale of all wheelchairs and crutches by prescription.

Since childhood I have been a wearer of such high-power aids myself, most of which were purchased without the services of an audiologist. I could not even spell the word "audiologist" when I got my first aid. None of these potentially dangerous devices, however, has injured me.

To put this level of danger into perspective for you, the Ontario chapter of the Canadian Hard of Hearing Association took the time to do a bit of comparative research. We contacted several large hearing aid dealers in Ontario and asked them to give us an educated guess as to what percentage of the aids they sold last year were in a category that might be considered as having the potential to be hazardous if misused. We received figures in the range of 5% to 15% of the aids sold even had the potential to do some harm.

At the same time, we conducted a few tests and found the following results: 100% of the portable stereo tape

players tested, for example Walkman, exceeded these same safety limits; all of the television sets tested exceeded these safety limits; 100% of the car radios tested exceeded these safety limits; all the car horns tested exceeded these safety limits.

Dare we ask when the government of Ontario will make it a licensed act to prescribe a stereo? How soon after protecting the consumer from their hazardous hearing aids will we see a law making it an offence to sell a car without a prescription?

We are certain that those who developed the wording of the bills had only good intentions in mind. However, we can only take the concept of not allowing the user to have a free choice in purchasing his or her own hearing aid to suit his or her own needs as an aggressive action of discrimination against a group of disabled persons in Ontario.

Over the years, many such negative factors have been placed in the laws by ignorance on the part of lawmakers. From what I have observed, it is usually much harder to remove discrimination from existing law than to prevent it in the first place.

So we again ask you to strike any part of this proposed bill that would in any way require a prescription for the purchase of hearing aids or any other hearing-assistive device. We, as the purchasers and users of hearing aids, do not feel that the recommendation or dispensing of hearing-assistive devices is in any way engaging in the practice of medicine, as the act refers to it.

We would also like to note to the committee that in no place that we have seen in the proposed legislation is the term "hearing aid" defined. The generic term "hearing aid" is not as finite as, say, the term "television set" or the term "automobile." Just where did the ministry plan to draw the line between a hearing aid and other hearing-assistive devices?

This is one of the reasons that there is such widespread consumer displeasure with the proposed bill. We have learned through past experience not to blindly trust those professionals who presently make recommendations in the field to select the best possible device for each of our individual needs. Now we see a law being proposed that would entirely remove all consumer input and decision-making, with no limits or guidelines as to just what devices would even be restricted. In a typical day, I use perhaps eight different devices to aid me in hearing. There is no mention as to which of these devices the government wants to deny me the right to purchase without a prescription.

Fear of the unknown is a major element in this controversy. Hard-of-hearing people in Ontario have just started to gain access through technology. They jealously guard that access and will not allow this or any other government to take away from them the ability to live a comfortable and normal lifestyle.

It is the policy of the Ontario chapter of the Canadian Hard of Hearing Association, when making presentations like this one, not only to point out the serious flaws in the legislation, but also to give positive recommendations as to how the situation can be remedied. I would therefore like to turn this presentation over to Ms Kortright, who is both

the secretary of the Ontario chapter and the president of the Toronto area branch of CHHA.

Ms Kortright: Thank you, Mr Ford. As hard-of-hearing consumers in this province, we feel that flexibility is paramount in the hearing health care delivery system. As one of the committee members pointed out earlier in these proceedings, and as the hearing instrument practitioners made very clear, there are presently rural areas in this province where there is little or no service. This constitutes undue hardship for many hard-of-hearing consumers, especially those of us who are seniors.

We feel that if the legislation were to go forward in its present form, service to our members would be even more restricted than at present. One example of this is that we heard from one retired individual in Lanark, Ontario, who is no longer able to drive the 120-odd kilometres to Ottawa or the 140-odd kilometres to Kingston to visit an audiologist to get a prescription for a new hearing aid to help him deal with a hearing loss he has suffered for the past 40 years. With the reduction of train and bus service, there is no readily available long-distance public transit in much of Ontario any more. This is by no means an isolated occurrence in this province.

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The Ontario chapter of CHHA is most concerned that if the acquisition of a hearing aid in this province becomes a licensed act, the already lengthy waiting period to get an appointment to see an audiologist would become even longer, if one could even get an appointment in rural areas. One of the major problems we face at present in hearing aid delivery is the fact that so many persons needing an aid give up before they get it because of the already lengthy waits and numerous visits needed to meet the assistive devices program criteria.

What consumers in this province would prefer to see is audiologists who spent the majority of their time doing Ministry of Health-funded aural rehabilitation with their patients. We feel that this is what audiologists studied so hard for and received their master's degree so deservedly for. Ontario would no longer have the glaring gaps in service it presently has if this were the case.

In my own work as a teacher of deaf and hard of hearing students in Toronto, I have had the good fortune over the past couple of years to work closely with and consult with an excellent audiologist attached to our programs. Her work is key in helping me to develop listening skills training programs for my deaf and hard of hearing students. She never prescribes a hearing aid, but may occasionally prescribe an FM radio frequency hearing aid such as the ones Mr Ford and I are presently wearing. I put it to you, Madam Chairman and honourable members of this committee, that it is for precisely this kind of work that audiologists are most properly trained.

As consumers, we feel we have the most vested interest of anyone in seeing that a better hearing health care system is developed in Ontario. Much has been said by others over the past few years in this area, but very little has been asked of the consumer by way of input. We have met with many individuals and groups around the province

in preparation for this presentation and feel we have the backing of most of the 400,000-odd hard-of-hearing citizens of Ontario.

We feel that the ministry has to start at the beginning, rather than by jumping into the middle of the fray, and, first, define the roles of all those who take part in the delivery of hearing health care. Then, with the assurance that all the bases have been covered, with accessible service we can move ahead into the future with the best possible delivery system for the needs of every hard of hearing citizen in our province. To this end, we have prepared a simple chart as an appendix to the report you have in front of you, showing the various service providers and the roles we, the receivers of this service, would like to see performed by those service providers. Thank you very much.

The Chair: Thank you very much for an excellent presentation. We appreciate your appearing before the committee today. If over the course of the hearings there is any additional information that you would like to present to the committee, please feel free to submit to us in writing.

J. SERGE LECLERC

The Chair: I would like to call next J. Serge LeClerc. You have 10 minutes for your presentation and we would ask if you would leave a few minutes at the end for questions from the committee, but that of course is your choice. You can begin your presentation now.

Mr LeClerc: This might be the most different presentation you have had in front of this committee. I appreciate being here as an individual to talk.

I have a certificate of study in social work. I am in my final year of an honours program at the University of Waterloo, with a double major. I am on the dean's honours list. I have helped establish an organization called Youth Working with Street Children. For the past year, I have been assistant executive director of a Christian organization with 10 ministries, two rehabilitation farms and four crisis pregnancy centres. I am a chapter director of Prison Fellowship of Canada, starting a pilot program of having Christian volunteers go into juvenile facilities. I lecture on the average of 12 times a year on university campuses. I speak throughout high schools and public schools throughout the province.

The reason why I do that is I was an eight-year-old street child. I was sentenced to St John's Training School at the age of eight. I was living full-time on the streets at the age of 12. I have spent 21 years in prison. I have spent 20 years as a drug addict. Five and a half years ago I had a grade 6 education.

I do not believe there is any doctorate in Canada who is more qualified than I am as a social worker with an honours degree to talk to street children, to talk to drug addicts and to talk to juvenile offenders. I take great offence that my protection as a social worker is not regulated, that I can talk to a 15-year-old girl in the counsellor's office after I do a school presentation, a girl who has suffered an abortion, where she has not been told the results of post-abortion syndrome, and I advise her to disclose and go get help, where I would be open to be sued

by the parents because they felt I gave her wrong advice and would embarrass them in the town they are in.

The reality is that there is one diplomaed PhD in your regulated workers per 300 prisoners in the prison system. The waiting list to see a doctorate personnel is up to a year. The reality is that 90% of the children in juvenile custody have been sexually or physically abused. There are no PhDs in juvenile facilities unless they are sent to a treatment facility.

The reality is that the backbone of people services who are working with street children, with juvenile offenders, with drug addicts, are non-regulated workers, they are social workers. I do not see someone with a PhD as more qualified than I in what I do. I am on the dean's honours list and I certainly have a world of experience to go with my academic qualifications.

Volunteer organizations have not been addressed in your piece of legislation and neither have social workers. There are a lot of qualified social workers out there and because they do not have a PhD does not mean that they should not be regulated. They should be regulated for the protection of the consumer to meet qualifications that apply in whatever qualifications would be given.

You have removed the basket clause that this piece of legislation was originally presented with because you had trouble defining the words in it. The basket clause for non-regulated workers should be instilled so that if you do not want to deal with people such as qualified social workers with an MA or an honours degree they are protected from some irate parent or an irate spouse and they are not receiving a \$25,000 fine or six months in prison.

You deal in section 23 with spiritual means according to the tenets of the denomination. It is very vague, the spiritual means. Can a Jehovah's Witness tell someone not to get a blood transfusion? Is that what you are saying? Is there a healing process within that? Can I tell a young boy that I became a Christian in the value system and the foundation of strength that I draw from? Is that offensive to a parent? Will a parent now say that I have tried to involve their young person in a cult? What about Christian counsellors? They are classified as unregulated workers. They are not covered.

1050

What about the volunteers who go into 40 prisons with Prison Fellowship of Canada? What happens with them? You have left them wide open and they are the backbone, really, of the social profession. Without volunteer organizations, all your PhDs or lack of PhDs are not going to replace the work they are doing right now. Can some irate parent get angry at a volunteer in a crisis pregnancy centre because she feels that that volunteer has convinced her daughter that there are alternatives to abortion and the daughter keeps it and the parent does not want to deal with it?

I have saved the government millions of dollars by becoming rehabilitated. The reality is that there is an 83% recidivist rate in the prison system. The reality is that there is a 40% illiteracy rate and an 85% functional illiteracy rate.

My last arrest was for a \$40-million conspiracy, a drug laboratory. We outgenerated Procter and Gamble in this country of \$120 million a year. By the use of volunteers who came to share a world of wisdom with me, they were able to do something that the government had never been able to do, or all the qualified PhDs were ever capable of doing.

If this legislation goes through, you may disband that whole organization and network of volunteer organizations and you may affect the social workers who are being on the front line with lack of protection. You may also affect the Christian community, which is probably the largest number of volunteers, doing what the government cannot pay people to do for lack of money.

Once again, if you remove the basket clause for unregulated workers, in my opinion it is very silly. You should put it back in and look at the vagueness of section 26. As the man who spoke a little while ago said, put something separate for Christian counsellors in there and Christian volunteer organizations. Thank you.

Mr Owens: The question is around your problem with diagnosis. I have done work with terminally ill patients in "counselling and support." I am just wondering how you feel that by providing supportive counselling you would be violating the diagnosis clause you have referred to.

Mr LeClerc: I do not know about terminally ill patients. I do not deal with terminally ill patients; I deal with street children, I deal with juvenile offenders and I deal with drug and alcohol rehab. None of those programs have got PhDs to them. The Roof program, Oasis, a number of programs—Evergreen, your best-known program here—all the people who are involved are master's levels of social workers, and 90% of the people who are doing the work are volunteers. They are not covered in this piece of legislation. You have removed the basket clause for non-regulated workers and I advise that you put it back in so there is some protection for the non-regulated worker—however you want to word that—and also for the non-regulated worker in the Christian community.

As far as diagnosis goes, I believe I can work with a street child and within 10 minutes have a handle on what the problem is. I believe in crisis intervention. I do not believe in the MMPI or all the other diagnostic tools the psychologists use, nor do I believe in long-range therapy. When it applies to a street child at 13 years old who is sitting on the track of your town and doing crack cocaine every 15 minutes, they are not the people the PhDs are going to address. That clientele is going to be addressed by the non-regulated worker and by the volunteer organizations that are not covered in your piece of legislation. It is a very dangerous piece of legislation in terms that it may disband all that. I do not know if I have answered your question, but I have certainly restated my opinion again.

The Chair: Thank you very much. We appreciate you coming before the committee this morning.

EUGENE STRAUSS

The Chair: I would like to call Eugene F. H. Strauss. Please come forward. You have 10 minutes for your presentation. We would ask if you would leave a few minutes

at the end to allow for questions from committee members. Please begin your presentation now.

Mr Strauss: I made a written submission a couple of months ago, not knowing that I would have the privilege of being here. Since then I have made a shorter statement to save some of your time and I hope that will be helpful. I think the clerk of your committee has—

The Chair: All the committee members have received a copy of your presentation.

Mr Strauss: Of the original one and of my statement?

The Chair: That is correct.

Mr Strauss: I have listened to a number of the other submissions this morning and I know of some of the others that were made on earlier occasions and I think I can state my concerns very briefly. I support the purpose of the legislation, which is to protect the public from unqualified or unscrupulous health practitioners. However, I am concerned about the perpetuation and indeed the intensification of unnecessary credentialism, specifically in the profession of psychology. I, like others before me, submit that a PhD in psychology, which can be earned through a thesis in industrial, experimental, developmental psychology or any other specialty in the field, is no better preparation for clinical practice than, say, a master's degree that has concentrated on psychological counselling or education.

The continuing role assigned under the new legislation to the Ontario Board of Examiners in Psychology threatens to perpetuate its past demand for a doctoral degree for eligibility for admission.

As an aside, I would add here that I was glad to hear earlier this morning that there had been a last-minute willingness to talk, but frankly I would rather the committee did something about the legislation, because the other is a little tenuous. This is the end of the aside.

I urge the prohibition of unwarranted credentialism in the legislation and that can then be tested in the courts. It does not define what it is, but it could be tested.

My second concern is the same as expressed to you by many others, and that is the so-called diagnosis clause, paragraph 26(2)1 in Bill 43, especially when it is read against the scope of practice for psychology and that is section 3 of Bill 63. The diagnosis clause is so all-embracing that it threatens to cut off much valuable and badly needed help offered by counsellors, ministers of religion and others who have specialized areas of social concern but who cannot qualify as psychologists, even under more reasonable criteria than those that have prevailed in the past.

Various ministers of health, I believe including yourself, Madam Chairman, and representatives of the ministry have maintained that it is not the purpose of the legislation to cut off such services. I accept that assurance but I urge that the legislation be written so as to reflect this. In this context I have included a suggested alternative text to paragraph 26(2)1 at the end of my written submission and I commend it to you for consideration. I would be glad to clarify anything I have said or written.

Mr Beer: I wonder if for the record you could tell us a little bit more about your suggested alternatives so that—

Mr Strauss: It is at the end and I have tried to stick as close as possible to the original text. All I have done is been a little more specific as to the kind of diagnosis—and the word “diagnosis,” of course, is not used—which should be restricted to people more qualified than say, somebody like myself to do it. I have talked about a disease which is a physical or neurological disorder or another medical condition as the cause of physical or emotional distress and dysfunction. That, I think, is the change.

The rest of the wording is the same. The present wording, in my opinion, is so broad that if I inadvertently say to a client as a family counsellor, “Could it be that your insomnia is due to the fact that you’re angry with your husband?” I am stating an opinion about the cause of a dysfunction and therefore would be breaking the law if I am not a member of the College of Psychologists of Ontario. I believe my wording is perhaps more specific and more to the point that, I think, was intended.

The Chair: I have a supplementary for Mr Cordiano on the same point.

1100

Mr Cordiano: I just wanted to know, from your opinion, how that would not be considered an assessment as opposed to a diagnosis, which is what we are trying to grapple with—the difference between the two?

Mr Strauss: Neither the word “assessment” nor “diagnosis” is presently defined. If it were, perhaps I would not have the concern. Nor have I defined it, of course. But I believe the more specific reference to medical disorders and other medical conditions emphasizes all that goes before is related to medicine and not social and interpersonal functioning. My concern is that the scope of practice for psychology is so broad—it deals with interpersonal relations, with intellectual functioning, almost any comment might be deemed to be a health professional comment which might be inappropriate for somebody who is not a member of the college. I of course support, in my first point, the earlier statement that people do not need a PhD in order to be eligible to do the work and they should be regulated and controlled of course. Can I help?

Mr Cordiano: We do not have any further time to get to the bottom of this.

The Chair: If, over the course of these hearings, there is any additional information that you would like to present to the committee you may do so in writing to our clerk at any time.

The committee recessed at 1101.

1110

HARALD DIENES

The Chair: I would like to call Harald Dienes. You have 10 minutes for your presentation. We would ask you to leave a few minutes at the end for questions from committee members.

Mr Dienes: If I might just introduce myself. I practised Chinese medicine here in Toronto and I am also currently teaching Chinese medicine at two schools.

I would like to introduce you briefly to Chinese medicine and why I feel Chinese medicine should be regulated in Ontario. Chinese medicine is a medical system complete in itself and has been used for a very long time. It is based on different premises than western medicine and also the methods of treatment are quite different.

It is different, but it works. That naturally poses a challenge to conventional medical understanding. The fact of whether or not it works was disputed for a long time mainly due to fraud research that was undertaken in the early years. Chinese scientists did not have the proper training in the western research methods and western scientists did not have the proper training in Chinese medicine to conduct adequate research, but that has changed. In the last 10 years maybe, there is abundant scientific evidence in support of Chinese medicine. The problem is that this is not widely known yet even in the medical community.

I think it is important to understand that the two medical systems are not in direct competition with each other because they serve two distinct purposes. Western medicine, obviously, is very useful for acute care and Chinese medicine is useful for chronic conditions. It seems it would be good if the two systems could be integrated. I mean, Chinese medicine should be integrated into existing health care.

The benefits would be twofold. The benefits to the public: Patients would have access to treatment that works and that does not produce side effects and the benefit to the government would be that it has been demonstrated that Chinese medicine is cost-effective so there could be savings there. There have been some studies done in the United States that confirm that fact. Those studies are available.

If in fact there is benefit in Chinese medicine, it would make sense to make it more accessible. How could the public benefit from a regulation of Chinese medicine? It would benefit firstly because of the adoption of a standard of practice. Chinese medicine can be potentially harmful if it is performed by an unqualified practitioner. Also, it seems necessary to adopt a minimum standard of competence to assure a high quality of the service.

For instance, I am teaching at the naturopathy school and there the requirements for licensing are 200 hours. In the Acupuncture Foundation of Canada, which is the acupuncture group, the medical acupuncturists require about 100 hours for certification of their members.

On the other hand, look at California. California was kind of a model for many other countries in terms of the acupuncture legislation. They require 2,400 hours of theory and 800 clinical hours. So the public has to be made aware that there are different levels of competence in their practice. In Ontario, the Chinese Medicine and Acupuncture Association has adopted a standard of practice which is a four-year course requirement.

Beyond standards of practice, I think it is important to address the scope of practice. I had a meeting last year with Mr Burrows and the question came up: Who represents the profession? Because there are a number of other health professionals that use Chinese medicine as an adjunct

to their practice, they all have some claim on the representation, it seems.

It seems to me because Chinese medicine is already a recognized profession in many other countries, the profession should speak for itself. Also, the consideration of the length of training requirement maybe should be considered. The last factor may be the question of international link. So, the Chinese Medicine and Acupuncture Association is affiliated with the World Federation of Acupuncture which is the governing body worldwide. I understand that the president of the association, Dr Cheung speaks to you on Thursday in London.

I want to point out that facts and scientific evidence in support of Chinese medicine are available, but it is not widely known. You may still be sceptical about what I say, but I would be happy to provide more information in terms of documentation or research articles or any further discussions.

Ms Haeck: This is more a question to counsel. Because of the acupuncture that may be used as part of the treatment, does that fall within the controlled acts?

Ms Bohnen: It would, except that the Minister of Health and her predecessors have said publicly that they intend there to be an exception to permit unregulated practitioners to continue to perform acupuncture.

Ms Haeck: Are they currently functioning under the Drugless Practitioners Act?

Ms Bohnen: No, they are currently functioning completely outside any legislation.

CHURCH OF SCIENTOLOGY OF TORONTO

The Chair: I would now like to call the Church of Scientology of Toronto. Please come forward and introduce yourselves to the committee. You have 20 minutes for your presentation and we ask if you would leave a few minutes at the end in case any members of the committee have questions. Please begin your presentation now.

Mr Smith: I want to thank you very much for allowing us this opportunity to speak to you. My name is Rev Earl Smith. To my immediate right is Rev Janet Leveau and to her right is Rev Nicole Crellin.

There are many positive aspects to this proposed bill. In particular, we welcome the announcement of greater public representation on the advisory councils. We feel this will provide greater public input and increased confidence in the public that complaints will be dealt with fairly by the colleges, particularly after the revelations that the College of Physicians and Surgeons of Ontario was not disciplining or dealing fairly with complaints of sexual abuse by patients about their doctors.

We were pleased to see that the government has also reaffirmed its position that the so-called harm clause is unnecessary. We also felt it would be disastrous to the public to introduce such a clause.

1120

It really leads us to what we think is the most contentious clause that concerns so many of us in the present proposed legislation with respect to subsection 26(2) of Bill 43. That is the diagnosis clause. It is the ambiguity of this clause which makes it so contentious and prevents the

public from seeking help from unregulated practitioners who feel prevented from doing their jobs by the wording of this clause. The present wording of this section does not differentiate between an assessment made by a regulated or unregulated health care practitioner and prohibits the unregulated practitioner from "communicating...a conclusion identifying a disease, disorder or dysfunction as the cause of symptoms of the individual," etc.

Clergy, pastoral care workers, social workers, distress centre volunteers, psychotherapists, chaplains, crisis centre volunteers, drug education counsellors and thousands of others in the health care support field would be affected. None of these people, volunteer or paid, would want to place themselves in a position to be a test case in court. All of those listed above are called upon to give an assessment or diagnosis by those who look to them for assistance and direction.

For example, a person calls up a crisis centre for help. The person is having a bad drug experience. The volunteer indicates the person has an addiction problem and urges the person to come in. We would see that as identifying some sort of disorder or dysfunction.

Another example might occur where a woman calls a rape crisis centre. She does not want to speak to a doctor or other qualified professional, but wants to speak to someone who has undergone a similar experience. This is just a possible scenario. She tells the volunteer she feels guilty. The volunteer tells her it is a normal reaction in the circumstances and not to feel guilty. She is depressed because of being raped and she should get some professional help. A disorder or dysfunction has just been identified. In addition, what if the woman still does not want help from a regulated practitioner, but prefers to receive further help from an unregulated practitioner who has undergone perhaps a similar experience?

Such volunteers or unregulated practitioners might be very reluctant to assist in such a circumstance where they run the risk of making a diagnosis or assessment and subjecting themselves to prosecution for violation of a controlled act. The ambiguity of this clause in the proposed legislation threatens the choice of the individual to seek the type of care they want or feel comfortable with. For personal reasons, some people will choose to accept help from an unregulated practitioner as opposed to a regulated practitioner.

The present regulated health care workers cannot possibly address all the social or spiritual needs of the people in Ontario. I think that is why there are hundreds of volunteers and agencies providing help and assistance to a wide variety of people suffering from many disorders and dysfunctions prevalent in our society.

That made us look at cost as well. You have heard this from the coalition of churches and several others. We agree. The financial burdens and implications of this bill are frightening if this volunteer sector could not continue its present work or was uncertain that it could continue its work. The volunteer sector contributes much and saves the already overburdened taxpayer millions of dollars in voluntary services which would be lost or might be lost due to the present wording.

The court system is already overburdened and would also be affected by those people with a "Let's sue" mentality. There are thousands of unstable people presently being served by our voluntary networks. Those with a "Let's sue" mentality would only be too willing to use a new piece of legislation to get at those who tried to help them. In addition, those with their turf wars or ideological disputes may engage in litigation, further overburdening our courts.

The Ministry of Health continues to say the diagnosis clause will not cause problems for the unregulated and that the unregulated would be free to talk to the clients. We recognize the ministry did not intend to affect clergy and pastoral care workers. These intentions, while laudable and reputable, are inadequate for protection when one is in front of a court of law. It is the letter of the law that must clearly express the intention.

You have heard many submissions from a wide variety of groups which all agree that this clause in the legislation clearly presents a problem to the unregulated practitioner. Obviously, it is not worded well enough or clearly enough if so many are objecting. We, like many other groups, have received the response back from the Ministry of Health saying it is not the intention for the clause to be interpreted that way. But it is Parliament's job to bring in the legislation and it is the court's job to interpret the legislation. Obviously it is imperative that the wording clearly communicate the intent.

How can this problem be resolved? That was a difficult one. We could not really think of a wording. We figured the simplest solution would be to remove paragraph 26(2)1. Disorders and dysfunctions could be almost anything in life. It would be impossible to name them all. It would be equally impossible to legislate the communication of our opinions on these matters to others. Even the word "disease" causes us a problem in that certain conditions, such as alcoholism, are seen by some to be a physical disease and by others to be a spiritual or social problem. Other common examples that cross these lines are stress, depression, drug addiction, emotional and physical abuse of spouses and/or siblings, marital difficulties and the list goes on. Again, some would see many of these as physical diseases, disorders or dysfunctions while others would see them as spiritual or social disorders.

Those people who are not regulated are often called upon to give advice to those who need help and they consider such advice reliable and useful. It can include what is wrong with us and what our problems are. The present wording of this clause restricts the communication of the unregulated, and even the public they serve, by not allowing them to speak completely and freely about the problems they are trying to address. You will very often find people more willing to speak freely with a minister or counsellor in a more relaxed environment than to a doctor in his office. Sections 29, 30 and 31 of this act prohibit anyone from misrepresenting himself as a member of a regulated profession. This seems to us to be adequate protection for the public from anyone making false claims as to credentials or representing himself as a member of a regulated profession.

We have thought and consulted with many other groups over the problem presented by the wording of paragraph 26(2)1. We just cannot see any way to reword it without at the same time infringing on one or more of the various unregulated practitioners. So we urge the committee to remove this clause if an acceptable wording that does not restrict the unregulated practitioner from performing their duties, services and responsibilities to the public cannot be found. We think the present wording presents more problems than it solves and does not serve the greater good of the public at large. Sections 29, 30 and 31 clearly provide what we see as the desired protection to the general public.

Mr Owens: My question is actually to counsel, through the parliamentary assistant, and that is the issue of litigation against the "unregulated practitioner." It is my understanding that people can now sue. This will not change. Do you know of any cases that are on record where somebody has taken his minister or counsellor or whatever to court?

Mr Wessinger: I will ask counsel to refer to that question of what suits there might have been.

Ms Bohnen: First of all, to speak of lawsuits or litigation is a little inaccurate. The provisions in this legislation do not create new civil causes of action. They create provincial offences. In other words, you cannot sue somebody in civil court for a violation of any of the provisions of this legislation. All you could do, if you were so inclined as an individual, would be to lay a complaint and try to start the criminal or quasi-criminal process; in other words, try to start the process whereby provincial offences are prosecuted in criminal courts here. That is exactly the same as the legislation now, whereby it is a provincial offence to practise medicine without a licence, to contravene the Drugless Practitioners Act and so on.

1130

The fact of the matter is that private prosecutions, which are what appear to be feared by many of the presenters you have heard from, are virtually non-existent. It is very difficult for an individual to start a prosecution. Police and crown attorneys prosecute in our system. Even if a private citizen is so motivated to pursue a private prosecution and bear all the expense of legal counsel and so forth, the crown attorney may exercise the discretion vested in the Attorney General to stay or discontinue prosecutions. But I think the bottom line is they are virtually non-existent in this country.

The Chair: Thank you very much for your presentation. We appreciate your appearing before the committee today. If at any time during the course of these hearings there is additional information you would like to present to the committee, please feel free to do so in writing to the clerk.

KIM SCOTT

The Chair: I would now like to call Kim Scott. Welcome to the standing committee on social development. You have 10 minutes for your presentation and we ask if you would leave a few minutes for questions at the end of

your presentation in case the committee members have any questions of you.

Ms Scott: I have come to speak about Bill 44, which requires that people with hearing impairment have a prescription in order to purchase a hearing aid. Before I express my feelings on this bill, I would like to tell you a little bit about myself. I am 26 years old. At the age of four I was diagnosed as having a congenital bilateral sensory-neural hearing loss. It is progressive, from the age of four where it was a mild loss to the point now where it is profound. I am to the stage now where I do not even know if I will have any hearing by the time I am 40.

My hearing loss has affected my lifestyle. I am trying to limit it as much as possible. As a child, it made it very difficult for me growing up. One of the biggest problems is the lack of understanding of people, especially educators, who did not understand the problems and how to cope with children with hearing impairment.

As I have gotten older, I have been fighting on my own. All my life I feel that I have been fighting to live as normal a life as possible. Right now I am on the road to achieving a dream. In one year my dream will be a reality, to work in a health care program. I want to be a respiratory therapist and I am going to be in one year. Unfortunately, I have had some barriers thrown up in front of me upon this. I have had people in the medical field who, unfortunately, are very ignorant. I expected them to be less ignorant than the normal public, but they were not.

I am going up to Sudbury to do a clinical rotation. Before I went I decided that I needed to have my hearing assessed. The little tell-tale signs were coming upon me: not being able to hear people, turning up everything very loud and having to turn down my hearing aids in order to hear satisfactorily and clearly.

I tried calling several audiologists throughout the city. I can speak for the three major hospitals in the downtown area—Toronto Western, Toronto General and Mount Sinai—because they all work together. All their audiology appointments were booked well into the month of September. This was three weeks ago. The only way I could get an appointment was if I got a cancellation and they were able to squeeze me in.

I have had this problem in the past where I needed new hearing aids, replacement hearing aids. To get an appointment with an audiologist is a real task. A few years ago I needed one new hearing aid of my two hearing aids. One of them broke and I required a replacement. I had to wait three months before I could get an appointment and that was with the Canadian Hearing Society on Spadina Avenue at Dupont Avenue.

Can you imagine what it is like being hard of hearing, where I am unable to cope with the use of one aid, waiting three months and living a day-to-day life that is extremely frustrating? My grades in school alone fell up to 20% in certain subjects. I am unable to work.

This was five years ago. Today my hearing loss has become even more profound and I now am to the point where I require hearing aids that are the strongest behind-the-ear hearing aids available on the market today. I cannot function with one hearing aid. I must have two, and since I

am going to be working in the medical profession, it is even more essential. If I have to wait several months before I can get an appointment to see an audiologist, which is what this bill would mean, I will not be able to practise as a respiratory therapist, because nobody will tolerate me waiting three months. I cannot risk the wellbeing of my patients by working with only one hearing aid, which is exactly what I would be doing. I work in trauma, I work a great deal in the intensive care unit, and it is a big risk I would not be able to take.

I feel that in passing this bill you are taking away my opportunity to fulfil my dream. I have always wanted to practise in medicine, always, since I was a little girl, and I have been working very hard at this. To pass this bill will make it even harder for me to have appointments to see audiologists. There are only 150 or so practising audiologists for adults in the province of Ontario. Somebody has said to me, "Well, there are over 13,000 practising physicians." Of course that is true, but no physician will prescribe a hearing aid for me without an audiogram performed. I mean, he would be negligent. He would be guilty of negligence to do otherwise.

To pass this bill is reducing my accessibility to a hearing aid when I need it. To have to wait several months before I can get the care I need is taking away my entitlement to live like all of you have the privilege to live day to day. And that privilege is going to be taken away from me.

I ask myself the question, "Why would they pass such a bill?" I came up with two answers, because it is obvious there is no proof whatsoever to suggest that people getting a recommendation for a hearing aid without a physician's consent can be harmful to them. There has been no evidence of that.

The only other two things that I was able to think of were: an attempt to cut back costs by reducing the accessibility of the service. That may be true in some ways. By reducing the accessibility you will discourage people from abusing the system, which, as somebody in the medical field, I am well aware the public does abuse our medical facilities, but you cannot do that by sacrificing other people who do need the service, and I am one of them.

The other thing I could think about was that audiologists would like to have a more true definition of what their role in the health care field would be. As somebody in the respiratory therapy field, a field that is also searching to have its role more clearly defined, I understand that; but I have never supported anything that, in defining our role, is going to sacrifice the care of the patient in any way. I am opposed to it.

As far as I am concerned we are a team, everybody. I do not care what you are in the medical field. I do not look at one higher or lower than the other. We are all a team. To worry so much about such a thing just because you want your role defined is, to me, illogical especially when it is sacrificing the care of the people who need it, and I am one of them. Thank you.

The Chair: Thank you very much for your very thoughtful presentation. The committee has wanted to hear from consumers and I think you have made a very important

presentation before the committee. I have two questioners. One minute, Mr Owens.

Mr Owens: As the Chairperson indicated, as a consumer I think you brought to the committee the kind of perspective we need.

Ms Scott: Excuse me, I am sorry. I am having a difficult time hearing you.

Mr Owens: As a consumer, you brought forward the kind of perspective that we need to hear. The issue of access is one that we are wrestling with and the hearing aid dispensers, I think, have articulated a very clear case that this legislation may restrict access. The audiologists come and say that is not true. So I am struggling with trying to find the middle ground of where is the reality here. Where do you see the reality?

1140

Ms Scott: I see the reality as a shortage of audiologists in the province of Ontario. There is no question of that. If you think of the number of hearing aid sales that happen in one year compared to the number of audiologists prepared to prescribe them to the patients and recommend them to a patient, there is, obviously. The other reality is having the waiting list to get an appointment to see an audiologist, so that there is a shortage.

A few years ago I found a solution to my problem in London, Ontario. I was again stuck with the problem of trying to get an appointment to have my hearing assessed—not necessarily to see an audiologist—as long as I could get an accurate audiogram and have a new hearing aid recommended to me. One of the hospitals I called—because they were telling me I would have to wait three to four months for an appointment in London, Ontario—recommended I call a private practitioner, a hearing aid dispenser. I called. I got an appointment within the week to have my hearing assessed. They assessed my hearing very well; I have seen so many physicians and so many audiologists throughout my lifetime that I am able to judge very well.

If these practitioners are wiped out, if they no longer offer these courses in the colleges—which would happen if you need a prescription to purchase a hearing aid—and they are not able to perform audiograms, the waiting list is going to get even longer. This is not something recent. This has been going on for years, and my mother, who is sitting behind me, will also tell you the problems she had getting the appointments to have my hearing assessed when I was a child. It is a long, tedious process. If I can get it done within a week, I will.

The Chair: Thank you very much for your presentation before the committee, and I think I speak for all members here in wishing you good luck in achieving your goal.

The Chair: Our appointment with Stephen Griew is cancelled because of illness; however, there is a written presentation available for all committee members from Mr Griew.

Mr Hope: Can I ask a question of counsel?

The Chair: We have some time if anyone has questions they would like to direct to the parliamentary assistant. Now would be appropriate.

Mr Hope: The question I have for counsel deals with the person who just did a presentation to us and also with the question of reassessment to improve hearing aids or to do an evaluation of the hearing loss. My first question would be, in order for somebody to go see a dispenser, do they need to go see a physician or an audiologist to get that first initial test done and a fitting? If they went to—

The Chair: Let us take one question at a time, okay?

Mr Hope: Okay.

Mr Wessenger: Yes, I will have counsel answer that.

Ms Bohnen: The relevant provision in the act is that a hearing aid dispenser may not dispense a hearing aid without a prescription. The act does not address, deal with or otherwise restrict hearing aid evaluations, testing, administering audiograms by anybody. It simply says you have to have a prescription for a hearing aid to be dispensed to you and that prescription can be issued by either an audiologist or a physician.

Mr Hope: Okay, so in clear language, if I go to a doctor and the doctor says, "You are losing your hearing. Go see a dispenser or an audiologist, whoever you wish," and I wish to go see a dispenser, and it proves that I have a hearing loss, then he can say to the physician, "Yes, there is a hearing loss and this is the prescribed hearing aid that has to be inserted into this individual."

Ms Bohnen: Yes, and in the presentation this morning from the Canadian Hard of Hearing Association, you will see that in their appended chart, as they see the relevant roles to be played by each health care provider, they see the role of physician ought to be—the general practitioner in particular—to determine if there is a medical cause for the hearing loss, or it is such that a hearing aid is the appropriate intervention, and that is essentially what this legislation supports; that people ought to go to their physician or their audiologist to determine if a hearing aid is what is necessary, and after that every other aspect of the process can be performed by a hearing aid dispenser.

Mr Hope: My second part to the question leads to the issue that once I have a hearing aid I have been prescribed, I wear it constantly and I find there is difficulty—as the young lady said she found difficulty—would she still have the right to see the dispenser for an upgrading, or would she have to go back to her family physician to be reordered to a dispenser or an audiologist?

Ms Bohnen: I would say, just as the finer points of when you need to go back to your physician before your prescription needs to be renewed; the finer points of when you have to go back to an optometrist before an optician can adjust your glasses, give you a new pair of glasses and so forth, are dealt with through standards of practice and discussions through the players in the system, that is how the details of when you ought to go back to a physician or an audiologist before having your hearing aid adjusted, upgraded, altered, etc, will be worked out in the field by these providers.

Mr Hope: I hope you do not mind, Madam Chair—you mean to say that, for instance, in the young lady's case where it is identified that there will be a continuing loss of hearing, it could be the understanding of the physician, the audiologist and the dispenser that the prescription be on an ongoing basis?

Ms Bohnen: One would hope, and I am sure, the dispensers are also knowledgeable enough to send their customers or clients back to physicians and audiologists when they see there has been a change or a deterioration, or there has just been such a period of time since the person has been assessed, that they ought to refer them back.

Mr Hope: I bring these questions up because listening to the young lady and her comments, living in a society, that I can imagine myself just shutting off and not being able to be here for a couple of days. I imagine as you get to the receding part of the hearing during a day and not being able to address the issue right away. This is why I am posing the question, is it able to have an ongoing prescription with your physician and your dispenser that they have identified the disease, disorder, dysfunction, and then, instead of doing a lot of travelling back and forth, you can deal with the problem on a more level base to make sure you do not face the difficulties she did.

Ms Bohnen: The legislation does not define at all what the prescription has to consist of, so the providers are at some liberty to figure out the appropriate way of dealing with these situations. For what it is worth, difficulties that are being described are current difficulties and past, historical difficulties. They are not problems caused by this legislation which, as you well know, is not law yet. I do not believe this government or the previous government thinks this legislation is going to solve all the problems of access to hearing aid services or any other kinds of medical services, because it will not. Lots of other things have to take place for those problems to be addressed.

Mr Hope: What we may see the legislation doing is providing a mechanism so that the complications being faced by the consumer base are maybe more informationally addressed in the system?

Ms Bohnen: The hope and belief was that the legislation would protect the public without at the same time throwing up unnecessary obstacles to getting the service people need.

Mr Owens: Through the parliamentary assistant to counsel, do we have any sense of the average time a person

spends on the waiting list to see an audiologist? The figures presented from speech pathologists in Thunder Bay indicated in that region there was essentially a month, but I do not know if that included audiologists as well.

Mr Wessenger: I will have counsel answer that.

1150

Mr Burrows: The data, as we understand it, that were presented previously to the committee were obtained from the ministry's assistive devices program. In fact, Linda and I participated in some discussions on this topic earlier and the data were verified as coming from the program. As with all data, I suppose they are subject to interpretation, but the officials in the ministry associated with that program concluded that in their opinion there was not an access problem and they had not received any complaints from the public about access. But it did appear from the data, if you look at them, that there are areas of the province where there may be problems and there are other areas of the province where it is clear there are no problems. I do not know if any more current data are available so I do not know what current trends may or may not be.

Mr Owens: Would it be possible to see if some more up-to-date data are available? I guess I take Ms Bohnen's point to heart that this legislation will not solve all the access problems this health care system has. However, I think I get a little bit nervous about what appears—and I say appears—to be a restriction on the folks who are dispensing hearing aids, especially in regions that may be under service by audiologists, as in northern Ontario, because then you are looking at perhaps northern travel programs and things like that.

Ms Bohnen: The added factor I think you should bear in mind is that access to hearing aid services and the manner in which the service is provided is also a function of the rules established by the assistive devices program, which has been forced to develop its program during this very long hiatus of waiting for legislation to be passed, and that also very much affects things. As I think Mr Burrows stated earlier, that program is driven by policy rather than law and it may be that adjustments will be made or can be made to that program's policies to respond to concerns about access which really do not result directly from this legislation.

The Chair: Thank you very much. I would like to adjourn the committee hearings now.

The committee recessed at 1152.

AFTERNOON SITTING

The committee resumed at 1400.

The Chair: The standing committee on social development is now in session. I would like to welcome everyone.

ONTARIO DENTAL ASSOCIATION

The Chair: I am going to call first the Ontario Dental Association. I would ask that you begin your presentation by introducing yourselves to the members of the committee. We would appreciate it if you would leave a couple of minutes at the end of your presentation to allow for questions from committee members if you wish. You have in total 20 minutes for your presentation and questions. Thank you very much. Please begin now.

Dr Somer: My name is David Somer. I am president of the Ontario Dental Association. With me today are George Sweetnam, who is also a dentist and is the vice-president of the association, and John Gillies, who is our executive director. I want to thank you for the opportunity to explore our thoughts on the Regulated Health Professions Act proposals with your committee.

The Ontario Dental Association represents more than 5,000 dentists. That is almost 90% of all the dentists in Ontario. I think you know that our initial statement complements the goals of the health legislation review. We have a long history of public advocacy. We have worked with members of the review team in an effort to achieve our shared goals, and we assure you that Ontario dentists will continue to work with the ministry with a view towards strengthening the public protection measures in this legislation.

I would like to call on Dr Sweetnam, who has worked on this project for many, many years now, to outline some of our specific concerns and recommendations about how to resolve some of these problems.

Dr Sweetnam: Madam Chair, members of the committee, in the handouts that you have been provided with, you might like to follow the two-page handout here with "Problems and Solutions." It is a very brief summary, and highlights the remarks I am going to make for the next few minutes.

As Dr Somer has indicated, the ODA believes that the legislation does not go far enough in protecting the public. We will begin with Bill 49, the Dentistry Act.

There is an omission in the authorized activities granted to dentistry. The only profession that has been granted the authorized act to apply or order the application of a form of energy prescribed by the regulations under the RHPA is medicine.

It is apparent to anyone who has visited the dental office that dentists routinely use numerous forms of energy. Lasers, electrosurgical equipment and high-intensity light are included among the energy forms that dentists employ in their practice. Given the role of dentists in providing such services, we believe the legislation should reflect existing practice by recognizing our use of numerous forms of energy in the dental office. We understand the specific forms of energy will be regulated under the

RHPA. We have provided initial information of energies used by dentists to the ministry, and we are complying with counsel's request to provide further details. However, we continue to believe that regardless of what specific forms of energy are stipulated in the regulations, dentistry should have this controlled act within its purview. We do not understand the distinction made between physicians and dentists.

The government already has prepared some amendments designed to ensure consistency throughout the acts governing the health professions. We were surprised that this omission was not resolved during that amendment-making process. Throughout the review process, we had been assured that no professional group would be denied the right to continue to perform services within its current scope of practice and educational training. To ensure that this legislation does not eliminate the ability of dentists to utilize necessary energy sources in their daily practice, we recommend that dentists be granted the authority to continue to perform this controlled activity.

Turning to the list of authorized acts for dentists, we find that the act, as it relates to the fitting or dispensing of dental prostheses, orthodontic appliances or devices, is incomplete. First, the RHPA proposals fail to recognize that the prosthetic appliances and devices involved should never be provided to a patient unless there is a diagnosed need for the specific appliance. A good prosthesis or other dental appliance will not benefit the patient if that is not the appropriate treatment option.

To ensure that patients have the benefit of a diagnosis prior to receiving such invasive treatment, we recommend that a prescription be required in order to fit or dispense dental prostheses, appliances or devices. This solution is consistent with other RHPA proposals dealing with appliances for both vision and hearing. We believe that the simple inclusion of the word "prescribing" will provide the important public protection measures which have been omitted.

To extend public protection to all identified areas of risk, the ODA recommends that the wording be revised. This section would then read: "Prescribing, fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect the teeth from abnormal functioning." We understand that the ministry staff agrees with the inclusion of the term "periodontal" and will not expand on this addition further.

Given the legislative model, this revised phrasing would be included in Bill 49, the Dentistry Act, and the omnibus act, Bill 43.

Moving on to the Denturism Act, we question the RHPA proposal to permit denturists the authority to fit and dispense partial dentures. This changes the current legislation. The technical skill involved in fabricating a partial denture is only one aspect of care for the patient who has some missing teeth. The central issue to successful treatment is the determination of oral health status and patient need.

A partial denture is only one of many different therapy options for patients with natural teeth. A diagnosis is absolutely essential to detect pathology in the oral cavity and to determine what treatment option is appropriate. Will the bone, gums and adjacent natural teeth support an artificial appliance? This requires clinical examination, including X-rays. Denturists do not possess the prerequisite skills and training to carry out this detailed examination. We agree that patients are entitled to a choice of where they obtain particular health services such as dentures, but only after it has been determined that this would be the appropriate course of treatment and that it could be provided in a manner which would do no harm to the patient.

Because partial dentures have a direct impact on a patient's natural teeth, a partial denture should only be fitted on the order or prescription of a dentist. This solution recognizes the skill and training of the denturist and at the same time ensures that the patient has received a comprehensive examination to determine the most appropriate treatment plan. Therefore, the ODA recommends Bill 50, the Denturism Act, be amended as follows:

"In the course of engaging in the practice of denturism, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to fit and dispense removable dentures for the edentulous and, on the order or prescription of a member of the Royal College of Dental Surgeons of Ontario, to fit and dispense partial dentures."

Dental hygiene: As we turn to Bill 47, the Dental Hygiene Act, we wish to recognize the valuable role of the dental hygienist in the delivery of oral health care. The dental hygienist is a vital member of the dental team. However, we believe that the broad scope-of-practice statement proposed for dental hygienists will lead to the fragmentation of the delivery of oral health care.

The elected officers of the Ontario Dental Hygienists' Association have stated repeatedly that hygienists do not support independent practice for dental hygienists. On this point, I will leave you with information to support this. However, this legislation proposes to grant dental hygienists the authority to provide preventive and therapeutic treatment services without the patient ever having been seen by a dentist.

The scope of practice of any profession should recognize the education and training of a profession. However, we must be careful not to confuse and equate technical skill with the corresponding ability to determine when to apply the skilled service. Seemingly simple procedures can lead to disastrous results for the patient when the service was not appropriate for the presenting patient.

We support an enhanced role for the dental hygienist and we anticipate that the hygienist will be required to work in more community settings providing care for the elderly in the future. We know that Ontario's population of older adults is increasing. This demographic trend impacts upon the delivery of oral health care services. More preventive and treatment services will be required for this population of older adults who are known to keep their natural teeth longer. However, the institutionalized elderly are an at-risk group. They often have an overwhelming

number of medical problems. As a result, designing oral health treatment programs for the institutionalized frail elderly is a complex task. Diagnosis of the patient's oral health status and the consideration of related health conditions and ongoing treatment are essential.

Cost control measures must not eliminate this initial step to the delivery of oral health care. All patients, including the institutionalized elderly, are entitled to comprehensive dental care.

We believe that granting dental hygienists the ability to work on the order of a dentist, rather than the current requirement of direct supervision, would facilitate the delivery of full-scope dental services to patients in institutionalized settings in a cost-effective manner.

We believe our recommended change to the wording recognizes the full role of the dental hygienist and is in keeping with the intent of the review:

"The practice of dental hygiene is the assessment of teeth and adjacent tissues and, on the order of a member of the Royal College of Dental Surgeons of Ontario, treatment by preventive and therapeutic means including the provision of restorative and orthodontic procedures and services."

1410

As we review Bill 48, the Dental Technology Act, again we ask the committee to consider public protection. In the absence of a controlled act, no guarantee exists that quality devices will be delivered. A dentist is not a metallurgist and cannot assess the quality of materials used before inserting the device in the patient's mouth. All that glitters is not gold. Only a registered dental technologist should be held responsible for delivering a dental prosthesis or appliance or device that has been ordered or prescribed by a dentist.

The ODA previously has recommended the inclusion of the following controlled act in the Dental Technology Act: "Dispensing fixed and removable prostheses and dental appliances and devices to a qualified practitioner pursuant to an order or prescription from a qualified practitioner." We recently learned that Ministry of Health staff are exploring an alternate amendment with the registered dental technicians, and we look forward to the opportunity to participate in that discussion. Without more details, we are not able to comment on that amendment at this time. We simply reiterate that our main concern is to resolve the situation in a manner consistent with the protection of the public from unnecessary risk of harm.

Finally, we wish to address one of the recent amendments to the RHPA. We understand that the ministry has proposed that the authorized act for nursing which permits nurses to administer a substance by injection or inhalation on the order of a qualified person has been changed to read: "Administering a substance by injection or inhalation on the order of a member of the College of Physicians and Surgeons of Ontario." This amendment was never discussed with dentists. Because dentists and registered nurses work together, this amendment will have a dramatic and unacceptable impact on the delivery of oral health services. We suggest that the committee revise this authorized act in the Nursing Act to ensure that current

interprofessional working relationships are not impeded unnecessarily. If the ministry intends to change the phrase "on the order of a qualified person" to make it more specific, they will have to ensure that this act includes each of the professions involved in this activity; for example, dentists.

We have appreciated the opportunity to highlight some of our concerns with the RHPA proposals. We will be presenting you with a more detailed brief on these matters and other issues later this month. At this point, we would be pleased to answer questions from the committee.

Mr Jackson: I would like to thank the ODA for clearly and succinctly setting out their concerns, for the appended guide to the five bills in particular, and for your reference to the elderly, which we have not had much detailed response on to date. So thank you for that.

Perhaps, Madam Chair, I could ask the ministry on the last point, with respect to the Nursing Act, if we could get some clarification on whether that was an oversight or if there was a purpose in being specific to the College of Physicians and Surgeons and the rationale behind that?

Mr Wessenger: I will ask staff to reply to that.

Ms Bohnen: I do not know if I would describe it precisely as an oversight. One of the purposes of the minister circulating the proposed amendment so early in the process was to get feedback. That said, I do not believe there will be any difficulty in adding a reference to a member of the Royal College of Dental Surgeons, and for that matter, members of other colleges whose members may prescribe substances that are administered by injection and inhalation.

Mr Owens: This morning we heard testimony from the folks involved in psychology where they announced what essentially turns out to be a landmark agreement to sit down with the various associations and boards to work out their difficulties. I am just wondering if that approach has been tried with the denturists and the folks who are involved and why did it not work. Or has it not been attempted, and why has it not been attempted?

Dr Somer: There have been many meetings in the past, and the differences in their respective roles were so great that we really are very much at an impasse. I think that we need to rely on this act to make sure that the roles are very precisely defined.

The Chair: Question, Ms Haeck?

Ms Haeck: Yes, to the parliamentary assistant. I would like to ask about the query the association has raised on page 2 of its submission regarding forms of energy, the second complete paragraph, "We do not understand the distinction being made between physicians and dentists," around the use of specific forms of energy. Can you comment on that?

Mr Wessenger: I will refer that to counsel, though I understand it has to be dealt with under the regulations.

Ms Bohnen: The intention is to regulate under the controlled act that specifically refers to hazardous forms of energy. The intention is to regulate forms of energy which may be hazardous, although they do not involve cutting or other invasive procedures, because that aspect of practice is captured by some of the other controlled acts. So the

intention is to list forms of energy which may be hazardous in some other fashion.

Indeed that controlled act is specifically authorized to physicians in the Medicine Act, because even on the most cursory review it is apparent that physicians will order and apply such forms of energy as electroconvulsive therapy. The list of forms of energy not having been prepared yet, it has not been so clear what other professions need to be specifically authorized to use those. Therefore, it seemed to be much more sensible to deal with the whole issue in the regulation under the RHPA and have it both list these forms of energy which must be restricted and identify at the same time those professions which must be authorized to order them or administer them, and all of the professions have been told that they will be consulted in the preparation of that regulation.

The Chair: Ms Haeck, the deputant would like to respond to your question if you would like to ask.

Ms Haeck: In fact I wanted to turn to you and raise the question of whether you have been working with the ministry on this issue and how you are feeling about this particular issue at this time.

Dr Gillies: Obviously we have had extensive discussions with ministry and ministry staff on this issue over recent times, but we still have two particular concerns. One is a technical one, and that is that if it is a controlled act for physicians, it is very difficult for our college to write regulations when there is no legislative authority for it to do so. The second is that in fact for dentistry, and this seems not to be well understood, application of forms of energy can be an extremely invasive procedure when you are using electrosurgical instruments and lasers which are cutting both hard and soft tissue. We really do not understand why there should be any differentiation between the surgical use of this type of energy by physicians and the surgical use of that type of energy by dentists. It just makes no sense to us.

Ms Haeck: I am very thankful for the association's remarks. I think I recently saw a picture which used the lasers. It does make it a lot clearer. Thank you.

Mr Owens: A quick question, through the PA to ministry staff. Again around the issue of denturists, I am wondering why the change came about. What was the rationale to allow denturists to do partials, as opposed to maintaining the dentist as I guess the access point to treatment, especially for partials?

Mr Wessenger: I will refer that to ministry staff.

Ms Bohnen: The Health Professions Legislation Review concluded, after considering, discussing and reviewing the submissions made by the provider groups, that denture therapists could safely and effectively dispense partial dentures without supervision. I would just add it is not the first time that a governmental commission had made such a recommendation in Ontario, but legislative change has not resulted from previous commissions' conclusions that denture therapists can indeed safely and effectively dispense partial dentures.

The Chair: I would like to thank you very much for your presentation. If there is anything further that you would like to make the committee aware of or you at any time feel that there is additional information that would be helpful, we would encourage you to submit it in writing. We want to thank you for your very thoughtful presentation today.

1420

COMMERCIAL DENTAL LABORATORY CONFERENCE

The Chair: I would like to call the Commercial Dental Laboratory Conference and ask you to come forward and introduce yourselves to the committee. You have 20 minutes for your presentation and if you will leave a few minutes for committee members, it would be appreciated. Please begin your presentation now. Welcome.

Mr Powe: Madam Chair, committee members, my name is Bob Powe, representing-spokesman for the Commercial Dental Laboratory Conference, better known as the CDLC. I am the past-president of the association and currently chairman of the legislative committee. With me are Jim Kerr, past-president and committee member, and Alberto De Luca, who is president and also executive director. In the gallery are Fred Bryan and our legal counsel, Stephen LeDrew. We definitely appreciate the opportunity to make a presentation and submission today. We will be brief, five or six minutes, I expect, so there will be ample time for questions.

The CDLC, or Commercial Dental Laboratory Conference, was formed 20 years ago, approximately. It is the only association in the province of Ontario which represents dental laboratories. The laboratory members include small laboratories and large laboratories: small laboratories being in the order of two to three persons; larger laboratories running up 30 to 50 people and even in a few instances greater than that.

The CDLC, in addition to representing the interests of dental laboratories in various matters, also carries out education with its members, including technical as well as managerial and overall business. We attempt to keep abreast of the technology, and it provides a forum for common problems for discussion of dental laboratories. That might give you a brief overview of the Commercial Dental Laboratory Conference.

The CDLC's involvement in the legislative review process has been one of very great involvement over many years. In fact, we have been submitting briefs for a 15-year period and more currently we have responded and submitted to the review committee. We have in addition met with other associations that are similarly affected.

The CDLC is not a profession in that sense. It is not a health profession. We are dental laboratories, and therefore the impact of the legislation certainly affects the commercial laboratory, because we have RDTs, registered dental technicians and technologists, involved.

Of all the interested associations submitting briefs over the period of the 15 years, we are probably unique in that our proposals and our position have been constant over the 15-year period. In essence, our approach to the legislation and our approach to carrying on business in a dental

laboratory is that an RDT be in charge of the technical aspects of commercial dental laboratories. One could substitute other words or terms for "in charge," but essentially that an RDT be involved and have responsibility for the final product.

Supplementary to that is that the CDLC has provided strong support for the upgrading of RDTs to provide a greater overall competence, not only technical competence, which is important, and probably relative to the discussions that are coming from review of this legislation are supervisory human relations skills and managerial skills that are involved or being requested of the RDT.

Where are we now in making our presentation here today, that is, the CDLC? We understand that there is a possibility of amendment to the omnibus bill. From our understanding of that amendment, the possibility is that the principles and intent are ones which we can support, subject to the final wording. We would like to have input on that if that does come to pass. We have no difficulty in supporting such a proposed amendment in principle, because the amendment, as we understand it, is consistent with the position that we have had over a 15-year period. To repeat what is that position, the position is essentially that a registered dental technician be in charge of the technical operations of a commercial dental laboratory.

In closing, I would like to thank the committee for giving us the opportunity to appear. We express our willingness to provide other input and to participate in any other requirements in the days ahead. We will be willing to entertain questions at this point.

The Chair: I would like to thank you very much for your presentation before the committee. Mr Hope, a question?

Mr Hope: One question. You say you represent both the registered and non-registered, if I am reading this correctly.

Mr Powe: Yes.

Mr Hope: And you are saying you would like to have a registered overlooking the non-registered?

Mr Powe: Essentially, we represent the commercial dental laboratory and we therefore have an interest in the registered dental technician and also other technicians who are not registered who are performing operations and so on within the dental laboratory, so that is when we say non-registered. The commercial dental laboratories have an interest in both groups, those who have achieved the qualification of a registered dental technician and those other technicians who are working in a dental laboratory who are not registered.

Mr Hope: With both of those technicians working in that field—and I am just trying to get a better understanding—would a non-registered be able, on a type of apprenticeship program, to achieve his registration through that, through direct supervision?

Mr Powe: Much of the training of dental technicians is done on the job in the dental laboratory under more experienced technicians, including registered dental technicians.

Mr Hope: So for instance, if there were no more non-registered dental technicians entering the field, then eventually we would phase out the non-registered and we

would just have all registered from now on. Just hypothetically thinking, we do not have the non entering the workforce any more, and through an apprenticeship training program where you are asking for direct supervision, we will no longer have the non-registered. Do you follow what I am saying?

Mr Powe: I am not sure if I am focusing correctly on the question. I would have to repeat that the commercial dental laboratories now take essentially untrained persons and, not through a formal apprenticeship program but through an on-the-job training program within the laboratory, actually train the individual in various phases of the technology, from very simple tasks and increasingly through more difficult tasks. That individual in due time has the opportunity to qualify as a registered dental technician through writing the exams of the Governing Board of Dental Technicians of Ontario as it currently is formed.

Mr Hope: Okay. Not being the knowledge of all, are there currently courses provided for registered? Where are we getting the non-registered?

Mr Powe: The registered dental technicians, as I have mentioned, can come up through the dental laboratory. It is not a formal apprenticeship program, but it can be a planned on-the-job training program, and after a period of time they can write an exam at the end through the Governing Board of Dental Technicians. Also providing registered dental technicians, or in some cases non-registered, is the three-year program at George Brown College in dental technology where those individuals can enrol, and there is a supply of graduates from George Brown College who are entering laboratories and being further trained. When they complete George Brown College in three years, they still are not eligible for registration. It would take at least another year in a laboratory, plus the writing of the governing board of dental technicians' examinations.

1430

Mr Owens: In terms of some of the new treatment modalities that are coming on stream, it seems a couple of times a year you hear about a new process, whether it is new plastics for fillings or screwing teeth directly into the bone. How do your folks keep up with these developments? Is there mandatory education? Is it company-sponsored education? Do they go back to George Brown College? How does this work so that they can keep on top and perhaps ahead of what is happening?

Mr Powe: That is a considerable challenge in most areas of advance in technology. The manufacturers—if we view possibly the implants as an example, the manufacturers of implants provide courses for persons in dental laboratories to qualify them to make prostheses in conjunction with particular implants that they manufacture. The training in some instances could be from George Brown as an additional, and many manufacturers and other professionals including dentists and registered dental technicians, have achieved the competence and skills to put on seminars and clinics. The commercial dental laboratory itself is very active in locating speakers and making available to its members and others that kind of an upgrade with this advance in technology.

Mr Owens: We had a presenter, I guess last week, a dental technologist who alluded to the fact that there were a number of illegal operations going on out there.

My question is, if we decide to make this a controlled act, how can we provide a good level of enforcement to ensure that these quote “illegal” labs are not still operating?

Mr Powe: My first statement would be, the first dental laboratory conference is not in favour of a controlled act of dental technologists. We feel that is not required. It is not geared to the responsibility that a registered dental technician should have and does not provide the dental technician, the RDT, with the scope that should be provided. We are definitely more in favour, we do support, the proposed amendment as we understand it. It would seem that coming out of that would be the requirements for enforcement in that legislation because I think there is a possibility that could be written so far as the laboratories are concerned and the operators of the laboratories. We do not support the controlled act. We think it is inappropriate for our operations.

The Chair: If, over the course of our deliberations, there is additional information that you think would be helpful, we would encourage you to send it in writing to our clerk.

ONTARIO PSYCHOLOGICAL ASSOCIATION

The Chair: I call now the Ontario Psychological Association. Please begin your presentation by introducing yourselves to the committee. You have 20 minutes for your presentation, and if possible we would appreciate if you would leave a few minutes at the end for questions from the committee members.

Dr Stasiak: Thank you for the opportunity to present the Ontario Psychological Association's concerns with the Regulated Health Professions Act and the Psychology Act.

Let me introduce to you the members of our panel. Dr Iris Jackson-Whaley is a psychologist in private practice and the president-elect of the association; Dr Ruth Berman is the association's executive director, and Dr Pierre Ritchie, the executive director of the Canadian Psychological Association and two-time former president of the Ontario Psychological Association, has been the chair of our task force on the Health Professions Legislation Review for over eight years.

I would like to note for the record that the Ontario Psychological Association fully endorsed the final report of the Health Professions Legislation Review with respect to both the omnibus bill and the Psychology Act. We believe that two of the subsequent changes made during the drafting of the legislation substantially weakened the principles that underlie the intent of the review's proposal as well as the intent of the governments of all three political parties that shepherded the legislation to this stage. Primary among these principles is the enhanced protection of the public.

I would like to call upon Dr Ritchie to describe the problems we see in the Psychology Act, how these problems have the potential for violating the principles to which I referred, and some solutions to improve the legislation in this regard.

Dr Ritchie : Merci, D^r Stasiak. Madame la présidente, j'ai l'honneur de vous présenter la perspective de notre société professionnelle.

I should also like to note that Dr Stasiak and I got back about 2:30 this morning from our American colleagues' conference. Some of us when we are tired slow down; I am told that I tend to gallop. So if I start to gallop and it is not making sense, would you just signal me, because when we rehearsed this morning this is what I was told.

When the Health Professions Legislation Review began, we had our wish list like everybody else. Today we have not brought a shopping list. We are not looking to eke out a little more to see if we can improve our standing. Our comments are not about the protection of turf. The case we put today is compellingly focused, we believe, on the protection of the public.

The problems we want to address are readily correctable. The OPA identified two problems with subsection 15(1) of the proposed Psychology Act as presently drafted. One involves title protection; the other deals with the term "health care to individuals".

The Schwartz report recommended a clear holding-out clause that would apply to all restricted titles. This provision would prohibit persons to take or use any name, title or description implying or calculated to lead people to infer that the person is qualified or recognized by law as a member of a health profession unless the person is authorized to do so pursuant to an act governing a health profession or group of health professions.

The current Psychologists Registration Act, in force for the past 30 years, while not containing the broad language recommended by Mr Schwartz regulates the terms "psychology" and "psychological" as well as "psychologist." To our continuing astonishment, the proposed Bill 63 only limits the title "psychologist." In other words, the proposed wording of section 15 is less stringent than the current provisions of the Psychologists Registration Act. This significantly reduces consumer protection and contradicts the intent of the proposed act to enhance consumer protection.

Under the proposed wording of Section 15, anyone regardless of training could legally advertise himself or herself as a consultant in psychology or as one who offers psychological services. Such individuals would not be accountable to the proposed quality assurance system nor would their clients have recourse within the regulated health professions legal framework.

The proposed wording would force members of the public to distinguish between a psychologist, who is regulated and trained in the provision of psychological services, and a consultant in psychology or a provider of psychological services, both of whom would be unregulated and perhaps untrained.

The OPA commissioned a nationally recognized polling firm, Environics, to undertake an Ontario-wide survey conducted by telephone this past June. Based on little more than 1,000 completed interviews it confirms with a margin of error of plus or minus 3% that 96% of the public expect that psychologists, persons with a practice in psychology and those who offer psychological services should

all be licensed. Yet under section 15, only the title "psychologist" would be restricted.

The OPA strongly urges that the wording of subsection 15(1) of the Psychology Act be amended to extend title restriction and thus consumer protection to include the terms "psychology" and "psychological" in line with the provisions which have proven very effective for over 30 years.

In the interest of time, I am not going to actually read the legislative text that we suggest, but you have it before you in bold print.

Alternatively, Bill 43 could be modified by returning to language originally proposed by the HPLR. This is a holding-out provision that would apply to the title restriction of all the regulated health professions. The proposed language for the amendment to section 30 of the Regulated Health Professions Act is again in bold print and again I will not read it.

1440

It is important to underscore that we know of no one among the proposed regulated health professions, nor anyone currently practising as an unregulated counsellor, who would be impeded in any fashion by maintaining the same restriction for the terms "psychology," "psychological" and "psychologist" as has already been in force for 30 years. We also know of no one representing any regulated or unregulated group who asked for the weaker title protection currently in the Psychology Act you have before you. On the contrary, representatives of consumers and other groups, including Professor Evans, have supported maintaining the title protection found in the Psychologists Registration Act.

The proposed act also refers to the provision of health care to individuals. This phrase, inserted into the latest version of all proposed acts, creates enormous problems for consumers, psychologists and a number of other professions.

This is legislation to regulate practitioners, not health care or health facilities. By leaving the phrase "health care to individuals" undefined the proposed act would create a two-tier system and reduce protection of the public. In such a system, for example, the title "psychologist" would be restricted only when one is providing "health care to individuals." In any other area of practice anyone could use the title "psychologist." This leaves the public without the protection of the act because the service being provided may not be considered health care by a court of law, even though the practitioner in each case has the same title.

What we suggest is simply to replace this phrase with "services in Ontario," and in that way these problems can be resolved, so that the proposed act would read, at the end of the pertinent clause, "in the course of providing or offering to provide services in Ontario."

Once again, we suggest an alternative. We have tried to come up with different solutions so that there would be some choice. If it is imperative that the phrase "health care to individuals" be retained, then the term "health care" should be defined in the act as the aggregate of all scopes of practice of the regulated health professions, exactly as

we have been repeatedly assured by ministry officials that this term is intended to mean.

There are two other matters on which we shall briefly comment before receiving your questions. We know the current language of the controlled act for diagnosis has been troublesome to many. OPA believes diagnosis should be a controlled act in the interests of public protection, but that an amendment to the wording of section 26 of the proposed act is needed to ensure all health care professionals may legitimately communicate their findings directly to their patients. OPA supports the sharing of diagnostic authority within defined scopes of practice and believes this controlled act should be extended to those professions able to demonstrate that diagnosis is appropriate to their scope of practice and who meet the criteria for inclusion as set out by Mr Schwartz.

We are aware a number of practitioners, both regulated and unregulated, have difficulty with the current wording of section 26. With other professions, we have tried to work throughout the review process to find the best language to express the principles Mr Schwartz espoused, while not inhibiting the legitimate work of other practitioners.

We remain receptive to the arguments of others to remedy their problems. When drafting an amendment or an exemption clause, we urge you to: retain diagnosis as a controlled act; retain the principle of independent authority for diagnosis within the scopes of practice of the professions that have already met and others who may meet the criteria for being afforded this controlled act; and retain Mr Schwartz's primary criterion of risk to the public as the determining factor for this controlled act.

It was this factor of risk to the public, as well as competence, which determined which professions were to be made more accountable for such health services. This is also why the solution of limiting this controlled act to medical diagnosis, a solution which we know has been presented to you, would in our view be so inappropriate. Such a solution fails to recognize the necessary development over the past several decades of additional autonomous professions which have highly specialized diagnostic skills. It is as inconceivable as it would be unjust to make physicians responsible for such diagnostic procedures since they are not trained to provide them. Even worse, the public risk would be significantly increased if only medical diagnosis were controlled. We again stress the importance of retaining the basic criteria adopted by Mr Schwartz. The control of psychological diagnosis as well as those other areas of diagnosis which present risk, must be retained as authorized acts to ensure the public interest.

The issue of the regulation of persons with a masters degree in psychology has been raised from time to time and continues to be raised with members of this committee, as it was this morning with the excellent presentation of our colleagues from the OACCPP. We would like to provide the following additional information to the committee.

Despite OPA's advocacy of either separate legislation for persons with a masters degree in psychology or a two-level act, the Health Professions Legislation Review concluded this was not appropriate, given what it wanted to

try to do. OPA repeatedly has been told that this matter is not part of the current legislative package. At this stage we do agree with our colleagues from the OACCPP that trying to force an artificial solution into the Psychology Act at the last minute is not an appropriate way to proceed.

We are, however, heartened that the proposed legislation will provide us with a forum, the minister's advisory council, to which further actions can be directed. We remain hopeful about the process—some of the positive results of which I think you have already heard this morning and you are hearing from us again this afternoon—that was encouraged by you, Madam Chair, during your tenure as minister, that has now gone on between OPA, its associate members, the OACCPP and more recently with OBEP also part of it. As you know, OPA has just signed a letter of agreement with these two other groups setting out both terms of reference and procedures for a joint task force. It is our hope that a proposal will be made for the advisory council's consideration once the new council is established. We have fixed for ourselves approximately 18 months. It is there in the agreement. That seems to fit what we think we need to get the task done and probably what it may take to get the whole thing set up, in any event.

I would also like to note that one of the main goals of our master's-level colleagues has always been to have an appropriate title. You now know that we all hope to be able to resolve this matter through the joint task force just established and we hope you will support this process and not constrain constructive options by only protecting the title "psychologist." Adopting one of our two proposed solutions is essential to help us achieve a resolution on this other matter.

All our comments today are discussed more comprehensively in OPA's complete brief, which has been submitted to the committee. We would be pleased to answer your questions.

Ms Haack: First and foremost, I thank you for your presentation. In speaking to members of the OACCPP this morning—that is a nice way of putting it, rather than the long handle—they definitely feel heartened by the discussions that have taken place in recent times around this whole issue of inclusion within their organization. I guess the one thing I have been hearing an awful lot of, in my riding office as well as here, is that there is this concern on the part of the unregulated, as well as the regulated, around the counselling function. I know you make mention of it, but this is definitely an area which is going to provide some discussions for some time. Any particular comments that you would like to make beyond what is on the printed page?

Dr Ritchie: Just as further background perhaps, I think we all appreciate there are two issues here which sometimes get blended but which, depending on how one is looking at it, need to be kept discrete. Master's-level persons in psychology often use the title "counsellor" when they are in a community because no other title is available to them. "Counsellor" is an unregulated title, and within all the acts that are coming forward now it will remain an unregulated title. There is nothing in the proposed

Psychology Act, nor would I anticipate anything that will come forward from our three groups, that would try to restrict "counsellor" to this particular group because it involves a much larger number of people than just those with masters' degrees in psychology.

The challenge is going to be to find that which will be appropriate to our colleagues within the psychological community in a way that is not going to inhibit other persons. As I mentioned, there are pastoral counsellors, marital therapists and so forth and they are not part of the framework of this legislation. We certainly would not be looking in any fashion to inhibit or delegitimize what they do, through our work.

1450

Mr Wessinger: Thank you very much for your presentation. I am very pleased about the progress you are making with respect to the establishment of this task force and compliment you on entering into the agreement with the other bodies. Just for my own information, and perhaps there are other members of the committee who might appreciate some elaboration, I wonder whether you could sort of explain in more detail what you mean by a "psychological diagnosis" and how that would differ from having, for instance, the unregulated body coming in and saying, "We say you have an alcoholic problem or you're feeling guilt," if you might sort of elaborate on that for the committee.

Dr Ritchie: I think perhaps the best way to do that is to draw your attention again, as I am sure other groups have done in their presentations, to the difference in our scope of practice, which is laid out in the Psychologists Registration Act, which is non-exclusive. It simply sets out the parameters of what psychologists do. But within the context of the scope of practice, "non-exclusive" does not preclude anybody else from doing those things and we authorize that, which is really just a very small segment of the total scope of practice. Even within psychological diagnosis, the wording is quite precise in the authorized act about that which is limited only to psychologists. I come back to that criterion Mr Schwartz used. Quite frankly, we would have preferred an authorized act that had much broader language, but in the end we were convinced that the logic he was using and the filter he was using was reasonable and that is, if you start with the perspective of what really could hurt the public, how could a patient be hurt if this kind of diagnosis is left open-ended?

In the case of psychological diagnosis, the language you find in the authorized act is that part which Mr Schwartz found to be the part of psychological diagnosis that really needed to be controlled, because letting other people do neuropsychological diagnosis, for example, really would present a risk to the public. I think it is important to underscore that distinction between the general scope of practice, which is non-exclusive, does not inhibit or preclude anybody else from doing what he or she does to the extent that it overlaps with that scope; and the authorized act, which is a very thin slice of the totality of what psychologists do, but that part which, we agree with Mr Schwartz, really does present danger if you let people

who do not have very advanced training do that kind of work.

Ms Jackson-Whaley: Could I answer that question from a slightly more practical point of view and from a different angle?

Mr Wessinger: Yes.

Ms Jackson-Whaley: There is a difference between a symptom and a diagnosis. A diagnosis, as psychologists do it, requires standardized procedures and training and assessment procedures that lead to a definitive statement of what is wrong with the person and how that came to be. A lot of people will say, "Oh, but you're depressed," or, "You seem to have a drinking problem," and those are not diagnoses. When clinical psychologists say that a person is depressed, they are speaking to a very clearly defined set of symptoms and aetiology or what went into creating that problem for that individual. I think there is quite a big difference.

Mr Jackson: On page 7 you referenced this committee as having heard of other groups that are having difficulty with their diagnostic authority. You point to the Schwartz guideline as giving further guidance. Could you share with us those groups or activities which are currently restricted that you feel could be expanded to be included. You speak in general terms here, but you do not give us examples that your professional association deems would be more appropriate if we were to—I do not want to say "liberalize"—this clause; you know what I am trying to ask.

Dr Ritchie: Yes, I think I do.

Mr Jackson: Can you give us some examples of that which would not fall in and that which would, because we are getting everything from a faith community to school settings in variety?

Dr Ritchie: As long as we will accept that I am not trying to be comprehensive and trying to include everyone who might be appropriate and therefore not be seen as deliberately trying to favour somebody more than somebody else, probably my own experience, which has been hospital-based to a large degree, and there may be others' that would be appropriate too.

I will cite you one example. I think the speech and language folks have made a very good case throughout that an important subset of what they do in the diagnostic realm really requires their highly specialized skills in order to assess and diagnose—just assess—but diagnose in the way it is meant to be used in this legislation. I think you have to look at the consequence of error and we are quite sensitive about other people making determinations about psychological diagnosis when they may not have a very complete knowledge. Therefore we are wary, particularly in a public domain, although we appreciate that is ultimately your job and you have to ask us to help you and you have to define who would be appropriate. But we are not experts in speech and language pathology. I am simply saying, as a clinician, as a colleague, I have been impressed by the case they have put forward, and there may well be others that each of my colleagues would point to as the one they would suggest.

We recognize, however, that if you begin with the notion of consequence of error, the risk to the public, you should be able to come up with a reasonable set of parameters and in that regard I think the ones drawn by Mr Schwartz are probably about as tight as you could get them. I do not think there is anybody to whom he accorded it who should not be there. I think it is reasonable to think there may be a small number of others who could.

The Chair: Thank you very much for a very excellent presentation. We appreciate your coming before the committee today. I think you know that if there is anything further you would like to communicate with the committee, you are welcome to do so in writing at any time.

ONTARIO BOARD OF EXAMINERS IN PSYCHOLOGY

The Chair: I call the Ontario Board of Examiners in Psychology. Please begin your presentation by introducing yourselves for the committee members and for Hansard. You have 20 minutes for your presentation. I think you already know we would appreciate if you would leave a few minutes for questions at the end of your presentation. Please begin your presentation now.

Mr Phillips: Thank you, Madam Chair, for inviting us and giving us the opportunity to talk about this issue. I am George Phillips, chief psychologist, London Board of Education, and am also chairman of the Ontario Board of Examiners in Psychology.

With me are Huguette Boisvert, who is our public member on the board, Dr Barbara Wand, who is the past registrar of our board, and Dr Patrick Wesley, the new registrar of our board. I thank you for being able to appear and I also have no excuse like Dr Ritchie's. I just talk naturally fast and I will try my best to slow down. Part of the difficulty, I find, is that this area has been talked about so much and we get going and I find I get wrapped up in it, so I will try to slow down and see what is going on.

The Ontario Board of Examiners in Psychology was set up under the Psychologists Registration Act of 1960. It has been regulating the professional practice of psychology for the past 30 years. There are some 1,820 registered psychologists providing services in Ontario and a further 100 on the temporary register in the process of becoming fully registered. During the past 30 years the board has created explicit and extensive standards of professional conduct, set rigorous criteria for entrance into the profession, developed a series of guidelines on various practice topics and established a detailed and user-oriented procedure to deal with public complaints.

The number of registered psychologists in Ontario has grown to almost 2,000 during the past 30 years. The board has accumulated experience in assessing the training and competence of persons from many provinces, the states and from other countries. Through the investigation of several hundred public complaints and through discipline tribunals of the board, a large body of knowledge and experience in regulating professional practice in the public interest has been established.

The Ontario Board of Examiners in Psychology exists to serve and protect the public, thus OBEP recognized and agreed with the main purpose of the Health Professions

Legislation Review. These were to protect the public from unqualified, incompetent and unfit health care providers, develop mechanisms to encourage the provision of high quality care and permit the public to exercise freedom of choice of health care providers within a range of safe options, while at the same time being able to distinguish between regulated and unregulated providers of care and promote evolution in the roles played by individual professions.

The legislative proposals now before the standing committee on social development reflect to a large degree the goals mentioned above. The new, uniform procedural code proposed in Bill 43 will make the disciplinary procedures of the professional body clearer, both for the members of the public and for the professionals. Additional powers to protect the public interest are given to the College of Psychologists of Ontario, as to all colleges in the procedural code.

1500

For the profession, the scope of practice proposed in Bill 63 and the requirement for quality assurance and continuing competency process will strengthen the board's efforts to promote high quality and professional improvement.

The board has considerable difficulty with the provision of Bill 63 in respect to titles that can be used which would allow the public to know what practitioners are regulated and therefore meet standards of practice, conduct, education and training. Under the present Psychologists Registration Act, the public of Ontario has a clear idea because three terms have been established by statute: "psychologist," "psychology" and "psychological." Over the past 30 years, Ontarians have come to rely on these descriptions as indicators of type and quality of service. The proposed Bill 63 removes the specific use limitations of two of these terms and will, if enacted, cause considerable confusion and will result in a major reduction in public protection.

I wonder if just for a moment you could turn to table A, which is right after page 5 in your document, so we could take a look at that table which looks at the complaints against psychologists, the types of complaints and the working settings. This shows you the kind of thing that OBEP has been doing over the past 30 years. I want to highlight custody and access complaints, which you will notice take place by private psychologists. We have had over 34, which is one of the largest ones, and with the present legislation as now stated, many of these people would not be registered or would not have to be registered.

The proposed Bill 63 removes all restrictions on the use of the terms "psychology" and "psychological." Consequently anyone, regardless of training, would be able to advertise a practice in psychology or psychological services. Further, by restricting the jurisdiction of the new college of psychology and the title "psychologist" to those persons offering health services to individuals, Bill 63 may withdraw regulation from significant areas of psychological practice such as organizational psychology, forensic psychology, custody and access or school psychology and psychologists in training education. Individuals, regardless of training or experience, will be able to use the title

"psychologist" if they are not providing health care. Legal opinion is offered in appendix A to support this argument.

I would like you to refer again to our document and look at the yellow pages. This is a little exercise we provided people to say this is what could happen where these various ads could suggest that these people are psychologists. The task is to ask which ones are psychologists and which ones are not. If in your spare time you take a chance to look at it, you will notice none of them have to be regulated.

The board believes that any amendments to Bill 63 should meet four criteria. First, the amendments should be within the spirit of RHPA legislation taken as a whole and consistent with the intent of the RHPA declared by the various ministers who have guided the proposals through to the present stage. Second, proposed amendments to Bill 63 should not affect members of any other profession covered by the legislative package, nor affect any professional providers of service not regulated under the RHPA. Third, public protection from harm should at least be maintained at its present level, if not enhanced. Fourth, the right of the public to exercise informed choice in the selection of service provided should be supported by any proposed amendments.

I would like you to turn to table J right after page 17. This outlines the proposals of OBEP. We are suggesting this as a proposal. We leave it with you for your consideration.

I want to now ask our public trustee to make a few comments on behalf of the public trustees of the board.

Ms Boisvert: Madame la présidente, distingués membres du conseil, my name is Huguette Boisvert and I am here as a private citizen and also as a public member of the Ontario Board of Examiners in Psychology since 1988. It is in that capacity that I wish to speak to you about the changes proposed in the legislation. The public members—we are three public members on that board—of the Ontario Board of Examiners in Psychology support the recommendations made to you by this board. We believe that informed choice in the selection of psychological services by the public and quality assurance in the provision of psychological services to the public are the two most important factors that must be addressed, protected and enhanced by any amendments to the legislation.

We believe also that the proposed wording does not protect the public's right regarding informed choice and quality assurance because under the proposed wording the terms "psychology" and "psychological" will no longer be restricted to psychologists registered by OBEP or by the new college. Therefore, we will have a multitude of individuals advertising themselves as providing psychological services, services in psychology or psychological assessments, to name only a few, who will not be registered, monitored or regulated by anyone with regard to the quality and appropriateness of the service they provide to the public. I am talking for the public, I am not a professional. You can see that.

I quote from a letter to a committee member from one of my public member colleagues on the board, Deborah Brooks of Sault Ste Marie:

"For over 10 years I was actively involved in special education in Sault Ste Marie. I am the past director of the chapter of the association for children with learning difficulties and a past member of the public school board special education advisory committee.

"In both capacities I came into contact with many parents and children who had been victimized by individuals who held themselves out to be qualified to practise psychology but who were not. Indeed, the task of ferreting out appropriate psychological care from the rank and file of counsellors, social workers, some therapies can be very difficult for many people. Nevertheless, mostly people do come to associate the terms 'psychological' and 'psychology' with the work performed by qualified, regulated practitioners and will seek care givers based on the scriptures of practice.

"In removing protection of the terms 'psychological' and 'psychology,' the RHPA will without doubt create an intolerable state of confusion. It will remove a vital element which enables the public to identify proper care givers and make informed choices."

The proposed wording also seems to exclude from accountability and regulation all psychological services that will fall outside the definition of health care, yet no definition is provided for the term "health care."

In closing, I would like to point out that as a mother of two dyslexic children and as a former school trustee for over 15 years, I am of the opinion that the public's right to informed choice and access to quality psychological service must be guaranteed and enhanced. I hope you will make the necessary changes to the new legislation to ensure that is so. I thank you very much, all of you, for your good attention.

1510

Mr J. Wilson: I almost got my question answered by reading the legal opinion, but I will try it. If we were to accept your proposals for section 15 and, I gather—continuing the extension of title protection to the other two derivatives, and just to play devil's advocate—if the negotiations you are now undertaking with the master's-level practitioners were to break down and we were to accept your proposal here for what I will call extended title protection, would that in any way impede the master's-level practitioners in their practice? Say they never make it to becoming full members of the College of Psychologists.

Mr Phillips: I could start with just a general response and state that it has not impeded them at present and that is the present law; we are not asking for any change. All three terms are there now, so that is not an issue as such. I see that the master's level is another issue on top of that. It is a new kind of issue.

Mr J. Wilson: But I see in your ads those terms are used, are they not?

Mr Phillips: Yes, they are.

Mr J. Wilson: So you have people out there supposedly practising who are not members of the College of Psychologists.

Mr Phillips: Probably who are being supervised by psychologists. They can practise under supervision.

Mr J. Wilson: So I have missed the gist. What is the problem with the ads then? Sorry, I am a bit slow today. I think I was up all night.

Ms Boisvert: It is misinformation for the public. The public is looking at it and need services. I look at it and I see psychological services. Already, I know that right now, it is registered. The act is there for that, but after the act, if it goes the way that it is now—

Mr J. Wilson: I see. Your yellow pages are examples of what would happen if we do not continue the protection. I am sorry I just missed that point.

Ms Boisvert: That is right. That is not the case.

Ms Haeck: Yes, Ms Boisvert, I would like to ask a question as a member of the public on this board, whether the OPA—and some of the members are still here as well as yourself—how to make the public much more aware of the psychological services out there. We have had the Consumers' Association of Ontario here and one of their extremely good solutions was around the issue of public awareness, public education. It is something that obviously, as you have all pointed out in your discussions—yes, there are unscrupulous people out there and we are all aware of that. But how do we really let the broad spectrum of the public know about the right service provider?

Ms Boisvert: It is such a hard question you are asking because in all the fields there is always a protection for the public. Yet we try; everybody tries their own way to arrive at that and it is hard, but one of the ideas anyway I can give you is to be seen, like having a workshop on information to people at large. Things like that have to be seen so that people will understand the differentials because the information is not the office of the rich psychologists, but it is not anywhere else except at the library. You have people there who will be able to have the right information, but very few have access to it.

Ms Haeck: I know the consumers' association is working with the Metro libraries and is coming up with a plan of making pamphlets and materials available for the public. Obviously, the more organizations that work with them, it will make this whole process much more valuable.

Mr Martin: As I sit here and listen to many of the deputants, I feel sometimes like I am standing on a tight-rope with the protection of the public on one hand and the delivery of service on the other, particularly where it impacts on northern Ontario which is where I come from. Right now, we have a difficult time getting qualified psychologists and other professionals into the north to practice. I am wondering if you might comment on how—and I noticed that the quote you used was from a woman from Sault Ste Marie—the limiting of the term "psychology" and "psychological" to people of your college might in any way enhance or detract from what is already a problem re northern Ontario and getting access to those kinds of services.

Mr Phills: I would like to refer to table D, which gives us a spread of where our psychologists are. We feel we are making some headway in that area. So much of it depends upon the training facilities that offer training in

the north, but at the same time I think we have made more headway in the last five years, I would say, than we have in the previous 10 years to provide service up there. Maybe I could ask Dr Wand if she would like to comment too because that has been a problem for quite a while.

Dr Wand: One thing to try to make clear is that when we are talking about enhancing title protection or limiting the use of terms, we are really trying to maintain the level of restriction on the use of these terms that presently exist under the existing legislation. I think it is important to make clear that we are not asking for any change from the present form of restriction on the use of these terms. We are concerned about the proposed Bill 63. The way psychological services are offered in the north would not be affected by our recommendation here. They would be retained. I understand there is a problem of attracting people to the north, but I think one of the important factors is that there are not too many jobs offered to psychologists in the north, so part of that is the availability of work for psychologists in the north.

The Chair: The deputation has asked for another few minutes to complete the presentation. We just have two minutes left. Do we yield the floor?

Mr Martin: Sure.

Mr Wesley: As a former faculty member, I just want to add that for 12 years in the north in the university, in psychology and in other experiences out there, the real key to this is not in terms of professional legislation at all; it is in terms of investment in the training facilities of northerners. I think that looking for changes in this legislation solves that kind of problem. It is really looking in the wrong place. The supply issue is not something that is controlled by legislation.

The Chair: I would like to thank you very much for your presentation. We appreciate your appearing before the committee today. If there is any additional information you think would be helpful, I know you will submit it to the clerk for the committee's consideration.

Mr Phills: We will.

1520

UNION OF ONTARIO INDIANS

The Chair: The Union of Ontario Indians, please come forward. Please begin by introducing yourself to the committee. You have 20 minutes for your presentation. We hope you will leave a few minutes at the end, if you would, in case any of the committee members have questions. Please be seated and begin your presentation now.

Mr Roy: My name is Alan Roy and I am director of the health program at the Union of Ontario Indians. With me is Ron Wakegijig, a traditional healer from Manitoulin Island, a former chief of Wikwemikong reserve, and generally considered a co-ordinator for a number of healers on Manitoulin Island and the north shore.

The Anishinabek Nation, represented by the Union of Ontario Indians, is a federation of 43 first nations located around the Great Lakes. They number about 25,000 and the members belong to the Chippewa, Ojibway, Odawa, Delaware, Pottawatomi and Algonquin people. Their

homelands, represented by treaties such as the Robinson Huron and Robinson Superior treaties, involve the watersheds flowing into the Great Lakes from Thunder Bay to Ottawa, from Sudbury to Windsor.

Each first nation employs community health representatives, alcohol and drug abuse workers and some employ public health nurses and other professionals on part-time contracts to serve the communities. Some communities have always had traditional healers and traditional midwives to provide their services upon request from citizens of these nations.

Our elders believe that the aboriginal rights to govern ourselves have never been surrendered and, as nations, we have the ability to pass laws, regulations and policies that govern our people. That concept includes the design, implementation and evaluation of our health programs and the duties of our health workers. Ontario has acknowledged this aboriginal right of the Anishinabek nation to govern itself in the aboriginal self-government paper ratified by the Ontario cabinet in 1990. This paper attempts to facilitate negotiations between the province of Ontario and first nations of Ontario in defining government-to-government relationships on all matters impacting on the lives of aboriginal people.

As there are approximately 200 staff employed in health programs by first nations, and many traditional healers as well as midwives serving the communities, the Anishinabek must ensure that their work status is recognized, protected and enhanced in light of any regulatory legislation proposed by this government. We have noted that Bill 43 attempts to control the activities of all health professions and health providers within the Ontario boundaries through various colleges sponsored and endorsed by the government of Ontario, which would include the colleges of physicians and surgeons, dentists, pharmacists, etc.

The legislation also includes the health service activities, listed in paragraphs 1-13 of subsection 26(2), which are prohibited unless a college has authorized a licence to a specific health provider. Many of the activities listed in this section are presently performed to varying degrees by the Anishinabek health staff and traditional health providers. I think Ron Wakegijig can be more specific later on, during the question period, about the types of activities that are actually performed. I have listed a number of examples there and I go on.

We have also noted that section 28 deals with the concept of exemptions to the principle of regulated control and licensing by a college, but our health providers are not mentioned. Also, I will point out at this time that some committee members have pointed out to me that exemptions may be dealt with by regulation. When I originally wrote this brief, I was thinking in terms of a clause right in the legislation somewhere that would refer specifically to aboriginal people and health providers.

Community health workers, alcohol abuse workers and band-employed nurses have to diagnose patients on reserve in the absence of doctors. In some cases, emergency situations have to be handled by the health worker, and immediate decisions must be made to transport patients to

a specialized facility. Many patients on reserve require the assistance with prescription drugs and injections of regularly prescribed medications.

In some cases, these health workers or nurses refer patients to traditional healers, or the patient will ask for advice on what services a traditional healer might provide. Many CHRs have delivered babies in emergency situations. These are front-line workers for public health on reserves, and they are expected to involve themselves in diagnosis, some treatment and assistive medical procedures at the demands of the first nation patients. The above list of activities in Bill 43 seems to threaten these health workers.

Traditional healers and midwives will be recognized, protected and evaluated by our first nations, and their duties performed by health staff in our communities will be monitored and work plans approved by the first nations' council. In order to avoid conflicts in jurisdiction and potential harassment by the medical establishment, we recommend the following amendments:

"That under subsection 26(4) or section 28e a specific amendment to the legislation include the exemption, recognition and protection of traditional healers, traditional midwives and health staff under the jurisdiction of first nations in Ontario;

"That Bill 56, section 2 include a definition of an 'aboriginal traditional midwife';

"That within Bill 56, section 5, add the concept of an aboriginal first nations midwifery council, which will recognize, facilitate and support midwifery within our communities;

"That within Bill 56, sections 6 to 14, all colleges, councils, registration committees, complaints committees and discipline committees will not affect the jurisdiction of first nations councils for midwifery in our communities. Rather, the activities of midwives, traditional healers and health workers will be supported by an Indian advisory council set up by the first nations themselves; and

"That both Bills 56 and 43 have a clause to provide for and facilitate the development of a separate and distinct advisory council, which could facilitate, promote and support health services within the Anishinabek nation."

In summary, our understanding was that the purpose of the committee in its review, or the legislation, was to devise new structures for control or enhance the structures for control; to decide which providers should be controlled; and to settle outstanding issues involved in health service delivery.

What we saw was an absence of any reference to our communities or the systems we use to provide health care to our clients, and we are talking only about citizens within our communities, as far as delivery is concerned. It is true on occasion that healers do deal with the dominant society, but for the most part we are talking about delivery within our own communities and control institutions within our own communities.

In the absence of an Ontario native health policy, the absence of an Anishinabek-Ontario political accord and the presence of the Ontario cabinet paper for negotiation of first nation-specific amendments with the government of Ontario, an opportunity to address these concepts should

not be lost. This proposed health legislation crosses the jurisdictional boundaries and could lead to serious conflict in future for Anishinabek health providers.

First nations are willing, able and indeed are community-directed to take responsibility for their community's institutions, which directly affect the lives of their citizens. First nations health providers historically have maintained an essential and culturally integrated service, and we cannot afford to have those services threatened or disrupted by the College of Physicians and Surgeons or any other control agencies within Ontario. It is therefore incumbent upon the standing committee for social development to consider that appropriate additional clauses be inserted in the legislation to recognize the concept of a separate and distinct development and facilitatory mechanism for the Anishinabek nation's health care.

Our policy development staff at the Union of Ontario Indians are available to work with ministry staff in drafting any such clauses to the legislation. I also tabled some questions, but I would like to make sure the members have a chance to question Ron Wakegijig on some of the health practices involved here. Maybe we could leave the questions to the end.

The Chair: Can I suggest that we have a few questions and then if there is time perhaps you can just state your questions for the record or, failing that, table them with the committee and the ministry will respond, and they can be part of the public record as well.

Mr Roy: Good suggestion.

The Chair: We have them on the appendix before us. There are five questions.

Mr Roy: Correct.

Mr Jackson: Gentlemen, thank you for your presentation. Let me ask you a question regarding the separate councils. Have you had any opportunity to speak to the new government about the recommendations, generally, about a separate advisory council or, in the case of midwifery, the separate council recognizing those services within first nations' activities in this province? Have you had any feedback from the government or any dialogue on these points?

Mr Roy: No. We have had some discussions with the task force on midwifery, but Ron Wakegijig has been trying to set up such a council in Ontario for traditional healers. I will let him comment on that.

1530

Mr Wakegijig: Basically we work with the federal Department of Health and Welfare Canada through our community health centre on the reserve. What we have been trying to do is set up an advisory council of traditional healers that will legitimize certain practitioners as being bona fide traditional healers. We are quite concerned, as the government is, about quackery as you call it. Unfortunately, there are people like that in both societies, people that take advantage of the ill health of certain individuals. There is a price to be paid whether it be monetary or deteriorating health of the individuals that are subjected to this quackery. We are extremely concerned over it and

we are in the process of doing something about it right now.

Mr Jackson: Madam Chair, perhaps I could request that, when we assemble as a committee on the 16th and maybe the 17th, we invite the ministry responsible for native affairs as well to respond to some of the questions the committee might have with respect to the points raised in this brief. I understand Health will respond to the questions. We appreciate that, and I am sure they will ensure that these questions are shared with the minister responsible for native affairs. But I for one would like to request, if there is agreement with the committee, that they also come forward to respond to some questions in this area.

The Chair: Your request is noted, Mr Jackson. Question, Mr Wessenger?

Mr Wessenger: Yes, thank you very much for your presentation. I was wondering if these recommendations have been discussed at all with other first nations.

Mr Roy: They have not. The other first nations were represented in front of the task force on midwifery, but I am representing the Anishinabek Nation here and just the federation that I have described in my brief. I am not sure why the other associations have not come in front of you, but I would say that I have heard similar concerns expressed in the other associations. I have been in this business for 20 years, and I know everybody else in the other associations, and I have been listening. So what I am proposing here is not out of line for all of Ontario, but I am speaking just for the Anishinabek Nation.

Ms Haeck: Thank you, also, very much. My question relates to your proposed amendments. You have, in the first one, said you would like to see an addition under section 28. I was wondering if you did not feel that section 28c gave the traditional healer the kind of empowerment needed to perform all those services.

Mr Roy: I understand what you are saying; however, we thought it was because this group is so distinct and because the Ontario government is trying to build specific relationships with aboriginal communities it warranted a separate clause distinct in its own manner. That is why I did not suggest along the lines of what you are suggesting.

Mr Hope: Just listening to the concerns that you bring forward—and I want to get to the treatment aspect of things, but before I get into that—on the consultation, this piece of legislation has been developed starting about 1982. What actual input have the Indian reserves and the first nations people had in this consultation process?

Mr Roy: As far as I know, this is the first opportunity we have had. The problem is the Ministry of Health never had an Indian health liaison unit within the ministry. There has never been an Indian health policy in Ontario. There has never been a preoccupation with the Ontario government dealing with the associations on matters like this, and I must say there has never been a preoccupation on the part of the treaty associations to deal with the province. We deal mainly with the federal government. But that has all changed in the last few years. Ontario right now is probably one of the leaders in Canada in developing relationships

with aboriginal communities. So it is late, and I understand the problem that you are alluding to, but there we have it.

Mr Hope: So it would just be a major stepping-stone in achieving some—

Mr Roy: This would be a big step.

Mr Hope: Along with self-government aspects of this government's initiatives.

Mr Roy: It would be a very big step.

Mr Hope: If further time allows, I would ask in more depth about the treatment aspect, if you would not mind commenting on it.

Mr Wakegijig: Well, first of all, I will just briefly describe part of what I do in the community where I come from and various other communities on Manitoulin and what we call the north shore of Lake Huron.

One of my specialty areas, if you can call it that, is diabetes among native people. We started a program about five or six years ago and I worked very closely, by the way, with orthodox physicians who come to our clinic. One of the big problems we are faced with is in the older population. First of all, they are illiterate in so far as reading and writing the English language is concerned. In their own language and their own culture they are extremely literate, as far as that goes.

So it is very hard for an old person. Let's say a senior in his 70s. He is diagnosed as having diabetes. One of the primary treatments for the control of diabetes is diet. It is very crucial. So when the doctor prescribes a certain diet for his patient, they are either very reluctant to follow it or they do not follow it all. As a result, in years gone by we have had people suffering from complications, or amputations have had to take place. People have gone blind. Their kidneys have failed. So what I do is follow-up work after a physician has made an official diagnosis that the person is diabetic. That is where I come along from the traditional point of view to emphasize the importance of dietary measures, dietary control of the diabetes. So coming from a traditional practitioner like myself, they are more receptive to it, because they figure it is part of the traditional treatment.

Furthermore, what I recommended—we had a lot of problems at the initial stages—was providing each of these diabetics with glucose monitors. So as a result, they are able to monitor themselves on a daily basis. As soon as they know something is going wrong with their blood sugar levels, they are able to do something about it themselves by readjusting their diet or the form of exercise they are capable of doing during the course of a day. So that is one of the benefits of traditional practice.

I have been practising traditional medicine for 25 years now. It is the symbol of these bear claws that I wear. Every bear claw represents five years of experience or whatever you want to call it. But I deal with psychological problems. I work closely with the psychiatrists at Manser Mental Health Clinic. If I suspect a child of having extremely complicated medical problems, I refer them to the family doctor that is looking after the Millard Clinic, with the recommendation that immediate steps be taken to have them examined here at the Hospital for Sick Children, which is a specialized facility. We have been quite successful

in that area. Instead of waiting for months to have a child brought down to the Hospital for Sick Children, it is only a matter of hours or a matter of days before we have him down here.

The Chair: I would like to thank you very, very much. Your presentation has been very helpful to the committee. Particularly the examples of the last few minutes I think have given the committee an insight into some of the challenges in the areas of provision of service for the native population of Ontario.

If, over the course of our hearings, there is additional information, I know you realize you can visit any of the members individually, but you can also submit in writing additional information to the committee that you think might be helpful.

We have officially received your questions. They are a matter of record, and I will refer them to the minister through the parliamentary assistant and ask the ministry to respond in writing for the committee during the course of our deliberations. Thank you very much for appearing today. We appreciate hearing from you.

1540

DENTURIST ASSOCIATION OF ONTARIO

The Chair: I would like to call now the Denturist Association of Ontario. Welcome to the standing committee on social development. Please introduce yourselves at the start of your presentation. You have 20 minutes. We would ask if you would leave a few minutes at the end for questions from the committee.

Mr Battell: Madam Chairperson, my name is Ken Battell and I am the president of the Denturist Association of Ontario. With me today are Cliff Muzylowsky, our vice-president, and Jurgen von Fielitz, the chairperson of our association's legislative committee. We are practising denture therapists.

We are delighted to appear here today to support the passage of Bill 50, an act governing denturism. For the members of our profession and for the consumers of Ontario, the Regulated Health Professions Act and Bill 50 represent a major victory over almost 20 years of arguments and studies about the fitting of partial dentures.

With the passage of this legislation—as proposed by the Schwartz commission, approved by Liberal Health ministers Murray Elston and Elinor Caplan, and introduced by Health ministers Evelyn Gigantes and Frances Lankin—consumers will finally have the legal right to have access to high-quality partial dentures at an affordable price.

This is a victory that is being loudly applauded by consumers and, in particular, senior citizens who tend to be the primary beneficiaries of the choice of which profession fits their partial dentures that this legislation provides.

In their submission to this committee, the United Senior Citizens of Ontario, which represents some 300,000 seniors through their 1,400 chapters across Ontario, has told you:

“We strongly support the proposed legislation granting denturists the right to fit partials without the supervision of a dentist because it will increase the access to good dental

care at more affordable prices. We believe that this legislation is in the interests of consumers and will lead to an enhancement of the quality of life of thousands of seniors who cannot afford partial dentures under the existing legislation."

Another major consumer organization representing seniors, the Ontario Coalition of Senior Citizens Organizations, which represents 39 senior citizen organizations ranging from the Big Trout Lake Indian Band to the Older Women's Network, have stated that they too vigorously support the expanded scope of practice for denturists. In a letter to the Denturist Association of Ontario, the coalition stated:

"Research has shown that high costs often prevent seniors from obtaining the dental services they need. Since this legislation will allow denturists to provide quality partial dentures at lower cost, it certainly deserves our full support."

We are delighted to have such vigorous support from consumers. However, while we understand that both the Minister of Health and the members of this committee have said they want to use these hearings to listen to what consumers think, we fully appreciate that in the course of these proceedings you are going to hear primarily from witnesses who are opposed to this legislation.

What the members of this committee need to understand is that this is not the first time the denturist-consumer lobby has won this argument. We have won it before on the merits of the case and then lost it when powerful vested-interest groups combined and successfully convinced politicians to back down. If I may, Madam Chairperson, it might be useful if I took this committee through a brief history of the struggle over the provision of high quality, less expensive partials in Ontario.

In 1972, under pressure from the Ontario Dental Association and the Royal College of Dental Surgeons, the then Minister of Health, Dr Richard Potter, introduced legislation which prohibited denture therapists from performing intra-oral procedures of denture therapy except under the supervision of a dentist. By law, our profession was not allowed to do complete dentures, let alone partials.

While the ODA and the RCDS promised the government of the day that prices would remain low if they had exclusive rights in the area of dentures, the fact is that prices continued to skyrocket. As a result, the government moved some two years later with new legislation, the Denture Therapy Act, 1974, which enabled denturists to perform complete dentures, but not partials.

At that time, both the NDP and the Liberals voted against that legislation, arguing forcefully for the right of denturists to make and fit both full and partial dentures independent of dental supervision. Indeed, a private member's bill was introduced by NDP MPP Mel Swart which sought to extend the practice of denture therapy to the provision of partial dentures. While Mr Swart's bill was defeated, our profession unleashed an unrelenting lobby campaign to review the legislation.

Finally, in 1980 Health Minister Dennis Timbrell agreed to assign the issue to the Ontario Council of Health. Following an exhaustive study by Professor Bernard Dickens,

the government released the Dickens report of 1981. This was our profession's first major victory.

The Dickens report recommended "that the Denture Therapy Act, 1974, be amended to permit a registered denture therapist to design, supply, adjust and repair partial dentures without supervision from a dental surgeon." However, while consumers and denturists were celebrating our victory, in response to an aggressive lobby by the ODA and RCDS, both the Council of Health and the government of Ontario backed down and refused to implement the recommendations of the Dickens report on the grounds of "public safety."

The health council stated, "Since the safety or otherwise of unsupervised practice of denture therapy has not been determined empirically, it may be desirable to design and carry out studies which would provide the empirical evidence needed for objective decision-making."

While the Governing Board of Denture Therapists, the Ontario Association of Denture Therapists and George Brown College each argued vehemently that there was no risk of harm, the ODA, the Association of Prosthodontists of Ontario, the RCDS and the faculties of dentistry at both Western and the University of Toronto argued that it might be harmful to allow denturists to do partials.

In their presentation, the dental lobby displayed pictures of gross anatomical anomalies that shocked the decision-makers of the day. The question was posed: How could denturists possibly treat such unhealthy mouths? The answer, of course, is quite simple. We would not. Denturists are trained to recognize abnormalities through the courses in oral pathology, biology, microbiology, histology, etc. We automatically refer such patients to qualified practitioners.

We do not work on unhealthy mouths. That is within the scope of practice of dentists, not denturists. Indeed, if a patient were to come into the office of a denturist with his or her mouth in the condition depicted by some of the photographs you have been shown, he or she would automatically be referred to an oral surgeon.

As the members of this committee are aware, one of the major focuses of the HPLR process over the past nine years was to uncover evidence of harm by practitioners. One of the reasons why the review and the last four ministers of Health supported the legislation before this committee is that no one has been able to come forward with a single case of harm involving denturists.

Prior to becoming Canada's ambassador to the United Nations, Stephen Lewis, acting in a consulting capacity to our association, told the HPLR team: "It is apparent to anyone familiar with this field that over the years thousands of partial dentures have been made and fitted—whether legal or illegal—and there is utterly no evidence, in the aftermath, of patient risk.... All the hints and intimations of the horror stories, all the lurid descriptions of what can go wrong, appear to be the stuff of sheer illusion."

As Mr Lewis stated, "Hyperbole is no substitute for fact." Indeed, it was on the basis of fact that Dickens recommended that denturists be permitted to fit partials. It has been on the basis of fact that the HPLR and a number of health ministers have recommended the passage of the

legislation that is before you today. Nevertheless, over the course of these hearings this committee will no doubt be subjected to a great deal of hyperbole and explanations by vested interests as to why they continue to believe denturists might do harm if you pass this legislation.

Those opposed to denturists fitting partials argue that because partials involve working with natural teeth, they pose a greater risk of harm than full dentures. However, in many cases denturists are required and legally permitted to fit both upper or lower dentures opposing dentate or partially edentulous mouths without dental supervision. Clearly, it is an odd distinction that allows us to legally place dentures in opposition to natural teeth but not adjoining them.

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It is important that the members of this committee understand that during the course of the past nine years of this process, the Ontario Dental Association has canvassed their membership time and again seeking real-life, specific examples of where denturists have done harm. None have been found.

While vested-interest groups might continue to produce pictures of unhealthy mouths and hint that this is what denturists could do if this act were passed, the fact is that there are no cases of demonstrated harm done by denturists. In fact, denturists have the enviable record of zero malpractice convictions in Ontario.

Indeed, there is evidence to indicate that quality of prostheses provided by denturists may in fact be superior to those provided by dentists. The July 1987 issue of *Journal*, published by the Canadian Dental Association, contains a study which we have provided at the back of this brief.

The evidence suggests that the quality of work performed by denturists is equal to or better than provided by the dental profession. This should not be surprising, given that denturists spend a great deal more time learning about the fabrication and fitting of dentures than dentists do.

Over the course of our three-year program of study, denturists spend 1,967 hours learning to manufacture prosthetics compared to a total of 331 hours spent by dentists. In our submission we have included a table that compares the removable prosthodontics curricula of dentists to denturists relating to prosthodontics.

In terms of price, the exhaustive study conducted by Dr Bernard Dickens for the Ontario Council of Health in 1981 found that "based on anecdotal evidence, numerous letters from the public, etc, the prices charged by denture therapists may be approximately half of those charged by dentists." Similarly, recent studies comparing the costs of dentures fitted by denturists versus dentists show that our prices remain considerably lower than dentists'.

I would remind members of this committee that since denture wearers are often seniors on fixed incomes, the issue of cost is critically important. Certainly that has been the historical concern of consumer groups.

Denturists have worked very closely with seniors and their organizations over the past 20 years to improve upon the dental care of the elderly. As you know, our profession, through Mr von Fielitz, was an active contributor to the

Hicks Advisory Committee on Dental Care for Seniors in Need. Indeed, denturists are the only dental profession who regularly make house calls to seniors in their homes and to elderly persons in institutions.

At the heart of Bill 50 is improved access to service and reduced cost. With the passage of this legislation, denturists will be able to provide services to the individuals whose prosthetic needs are covered by government programs such as welfare, the Department of Veterans Affairs and the Workers' Compensation Board. We will also be able to provide subsidized services to seniors living in homes for the aged, to residents of psychiatric hospitals and in homes for special care, all at reduced costs to the taxpayer. What denturists offer are faster, less expensive, more accessible, high-quality services to the public.

In summary, this legislation provides for a system of dental care in which consumers will have greater choice, improved access to services, equal or better quality, and less expensive partials. That is why the Denturist Association of Ontario, the United Senior Citizens of Ontario and the Ontario Coalition of Senior Citizens' Organizations urge you to pass this legislation unamended.

I would like to conclude these remarks with a point that will not be obvious from either this presentation or from submissions you have heard from organized dentistry. That point is the importance of the co-operative relationship that actually exists between denturists and dentists.

I think it is important to recognize the distinction between official voices of our professions and the real world. The fact is, denturists and dentists often have excellent working relationships. Many, if not most, dentists recognize the expertise of denturists in the field of prosthetics. We often refer patients to each other, and in most cases we have developed good working relationships that benefit our patients.

What you are seeing played out before you are the last agonizing jabs between organized dentistry and organized denturism after 20 years of official strife, but these arguments do not in fact reflect how the oral health care system actually operates in today's environment. That is why it is so important that this legislation be passed and put behind us, once and for all. We recognize, as do our colleagues in dentistry, that we must continue to build on the very positive co-operative relationships that have developed in recent years to the benefit of our patients and, frankly, to our mutual benefit as well.

We would now be pleased to answer any questions.

Mr Muzyłowski: With your permission, I would like to give you a very brief demonstration that hopefully cuts through some of the rhetoric and gives you a better understanding of exactly what the problem is we are facing.

The Chair: By all means, the time is yours. Please proceed.

Mr Muzyłowski: I have prepared some models here. I will take the liberty of standing up. For instance, denturists are legally entitled to examine patients and construct full dentures. This is a model resulting from the impression of a complete denture. The model represents an

impression of a complete denture. Often in the process of constructing complete dentures, uppers and lowers, we encounter situations where there is a partial dentureless lower opposing the upper. There are two teeth. This would represent, obviously, a partial to be made. We are legally entitled to take an impression of that mouth, examine it and make an assessment of the whole situation. We obviously have to do that.

We are entitled to make bite registrations, also for the lower. These two go together, the upper and the lower. This is all within the legal scope of our practice. We can then complete an upper denture. The moment we want to make a lower denture, the whole thing becomes illegal and we are facing a six-month suspension. Yet we can work legally on the dentureless and on the partially dentureless case. Where it comes to a process of designing, surveying and manufacturing the denture and putting it in the patient's mouth, we cannot do it. Here our expertise is far greater than the dentist's. As our accompanying appendix will show, prosthetics-wise we are trained far better than is being done at a dental college.

This shows how ludicrous the whole situation is.

Mr Owens: I was pleased to hear about the co-operative relationship you want to maintain with the dental profession. If I come into your office and I do not have the kind of gross pathology that you referred to in your presentation, do you have any kind of a requirement or a suggestion to me as a patient, because you would not know me if you fell over me on the street, that I see a dentist to ensure that there is no latent pathology before you start to work on the dentures?

Mr Muzylowsky: Yes, we do refer the patient to a dentist. We suggest to the patient that he or she will see a dentist prior to the fabrication of the partial to be entirely sure. I think this is just a reasonable thing to do. We will tell the patient, and then it is up to the patient of course to do that. A patient may say, "I'm sorry, but I have seen my dentist two, three, six months before already and my mouth is fine, and I refuse to go back."

Mr Owens: Would you then ask for records so that you have a reference point to start from?

Mr Muzylowsky: We, of course, have had difficulties in the past to get records. A record in this case would be a

record from the dentist or the practitioner who looked after the patient and it often would be very difficult to obtain.

Mrs Marland: I will tell you right off the top so that you do not hear it when you leave the room: I am married to a dentist.

Mr Muzylowsky: Aha.

Mrs Marland: I am being very fair. I am also intrigued that your exhibits are in a candy box. I think that is great. If the people—

Mr Muzylowsky: It is a gift from a dentist.

Mrs Marland: If they ate what was in the candy, that is why they need the full dentures.

Very seriously and very respectfully, I would like to ask you, when you compare the number of hours in your training where you learned to manufacture prosthetics, in those 1,967 hours you refer to, how much training or instruction do you receive in the basic health sciences?

Mr von Fielitz: As a graduate of George Brown College, having taken the denture therapy program, I feel I can best answer that question.

A good deal of our curriculum is spent on areas of concern, not only basic science but also dental science. Requirements such as histology, anatomy of head and neck, orofacial anatomy, oropathology and general medicine are part of our curriculum.

I believe as part of the submission by the Governing Board of Denture Therapists they included a copy of the three-year denture therapy program objectives. Spelled out in the objectives are the number of hours that are actually spent in these areas of the basic and dental sciences.

Again, we receive a great deal of training which would allow us to recognize normal and abnormal situations. It is not our scope of practice to make a diagnosis but to recognize the situation and refer individuals to the appropriate practitioner.

The Chair: Thank you very much for an excellent presentation. Time has run out. I know that Mrs Marland can continue her questioning privately and individually. If there is additional information you think would be helpful to the committee, feel free to submit it in writing.

The committee adjourned at 1602.

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